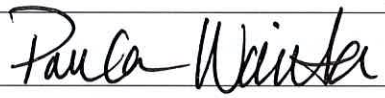
Catholic Charities Disabilities Services	
Agency Standard and Procedure	
Standard Category	Individualized Community Services
Standard Title	Traumatic Brain Injury (TBI) Waiver Services
Regulations	1) TBI Program Manual June 2025 2) Application for 1915(c) HCBS Waiver: NY.0269.R05.00 3/1/24 Appendix J 3) DOH C2.6 4) DOH C2.2
Original Issue Date	10/04/2024
Latest Revision Date	11/14/2024 11/26/2025 07/21/2026
Number of Pages	52
Attachments	
Approved by: Paula Warika, Executive Director	

Standard:
The Individualized Community Services department supports people with Traumatic Brain Injury through the NYSDOH Traumatic Brain Injury (TBI) Waiver Services. Billing procedures, records retention policies, and service documentation requirements are included in this standard.

Contents

Personnel Policies....2
Hiring Staff and Verifying Qualifications....2
Provision of Supervision....4
Recordkeeping....4
Establishing and Maintaining Participants Records....4
Informing Participants of their Rights including HIPAA....8
Waiver Participant's Rights and Responsibilities....8
Waiver Participant's Responsibilities....9
Documenting Participant Contacts and Service Notes....10
Intake and process for completing ISP, RSP and Addendum....10
The Service Plan....11
Services via Telehealth....18
Billing....26
Incident Reporting....27
Serious Reportable Incidents (SRI)....27
Recordable Incidents....30
Provider's Serious Incident Review Committee....35
Agency Policies....36
Canceling Services and/or Providing Back-Up Staffing....36
Changing Service Providers at the Participants' Request....37
Accessing Services and Supports on behalf of the Participant....40
Filing a Complaint/Grievance....40
Quality Assurance and Assessing Participant Satisfaction....41

Service Coordination 47
Safety and Medical Emergencies After Hours 47
Required Training for providers through CCDS 48
Basic Orientation Training 48
Service Specific Training 49
Annual Training 49
Training Employees concerning TBI Waiver and Participant Rights 50
Community Transition Services 50
Scope of Services 50
Community Transition Services for Individuals enrolled in the TBI Waiver 50
Procedure ..... **Error! Bookmark not defined.**
Contacting the CCDS Service Coordination Department, outside of normal working hours 51
Billing 51

Personnel Policies

Hiring Staff and Verifying Qualifications

Policy:

To assure qualified staff are hired to fill the positions of Service Coordinator all Catholic Charities Disabilities Services staff will be chosen in a non-discriminatory process. The most qualified person who best meets the needs of persons receiving services will be offered the position for which they are qualified.

The TBI Program Manual was updated on June 2025. Per the manual, any currently employed waiver provider staff who met the waiver application qualifications which were in place on the date of their hire are approved to continue to provide services. Approved employees may receive a certificate of qualification to provide services. The issued certificate will allow that staff member to continue providing the same waiver service(s) at both their current location of employment and/or any change they have in future employment locations/agencies. This certificate has no expiration date and only applies to the waiver service they were qualified for upon hire. Certificates may be terminated at the discretion of the New York State Department of Health.

Persons employed as Service Coordinators must be a/an:

- Licensed Master Social Worker (Licensed by the NYS Education Department);
- Licensed Clinical Social Worker (Licensed by the NYS Education Department);
- Individual with a Doctorate or Master of Social Work;
- Individual with a Doctorate or Master of Psychology;
- Licensed Physical Therapist (Licensed by the NYS Education Department);
- Registered Professional Nurse (Licensed by the NYS Education Department);
- Certified Teacher of Students with Disabilities (Certified by the NYS Education Department);
- Certified Rehabilitation Counselor (Certified by the Commission of Rehabilitation Counselor Certification);
- Licensed Speech Pathologist (Licensed by the NYS Education Department); or
- Licensed Occupational Therapist (Licensed by the NYS Education Department);

AND An individual meeting any of the qualifications above, must also have at a minimum, one (1) year of experience providing case management/service coordination and information, linkages, and referrals regarding community-based services for individuals with disabilities and/or Traumatic Brain Injury.

OR Individual with a Bachelor's degree must have three (3) years of experience providing case management/service coordination, information, linkages, and referrals regarding community-based services for individuals with disabilities and/or Traumatic Brain Injury;

OR Individual with an Associate's degree must have five (5) years' experience providing case management/service coordination, information, linkages and referrals regarding community-based services for individuals with disabilities and/or Traumatic Brain Injury.

Paid employment providing case management/service coordination, information, linkages and referrals regarding community-based services for individuals with disabilities and/or seniors can be used to fulfill the requirements for being employed as a Service Coordinator.

Any currently employed Service Coordinator who met waiver application qualifications upon hire, will be issued a certificate allowing them to continue providing the same services at both their current location of employment and/or any change they have in future employment locations/agencies. This certificate has no expiration date and only applies to the waiver service they were qualified for upon hire. Certificates may be terminated at the discretion of NYSDOH.

Verification of Provider Qualifications Entity Responsible for Verification: NYSDOH waiver staff and its contractors (RRDCs) for provider (practitioner) credentials. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license, registration or certification. Frequency of Verification: Upon signed provider agreement. The waiver service provider must report any subsequent change in status to NYSDOH waiver staff and/or its contractors (RRDC). For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license, registration or certification. NYSDOH Office of Aging and Long Term Care (OALTC) surveillance staff and/or NYS Office of the Medicaid Inspector General (OMIG) staff verify employee qualifications and certifications through surveys and/or audits.

Procedure:

1. The agency receives resume/application and TBI employee verification of qualifications form for the available position(s).
2. The Director or designee reviews resume and qualifications form. <u>If there is a question on the qualifications, RRDS will be contacted and the resume reviewed.</u>
3. The qualified applicant will give permission for a criminal background check as well as check the NYS Statewide Central Registry. The Human Resources (HR) Department will complete these checks along with a Medicaid Disqualified Provider Check on the Medicaid website. The Director will conduct interviews.
4. The most qualified and best-suited applicant will be chosen for the position and given a job description. Special attention will be given to the criminal background check and the driving record.
5. After the criminal background check/Statewide Central Registry and Medicaid Disqualified Provider Check is completed and applicant is cleared, the applicant can be offered the position. Upon their acceptance, a letter of hire with job specifics will be completed. Also completed at this time will be the new hire packet, which includes but is not limited to: W-4, copy of driver's license, social security card, proof of vehicle insurance, signature sheet for keys, Personnel Policies signature sheet, Employee Training Record Sheet, TBI Training Record, the training packet is initiated

6. All completed forms, reports and identifying information will be maintained in the employees' personnel file. The background check results, Central Statewide Registry and Medicaid Disqualified Provider results are maintained in a separate binder by the HR Department.
7. The HR Department will check the Criminal Background Check secure message center. Any changes in a staff person's status will be addressed immediately.
8. The Director or designee will train the SC and inform the RRDC as to the SC's date of hire which will prompt the RRDC to schedule the interview which is necessary prior to the SC providing TBI waiver services. This needs to be completed within thirty (30) days of date of hire.

Provision of Supervision

Service Coordinator Supervisor

All agencies that employ two (2) or more Service Coordinators must provide supervision by an individual who fully meets the qualifications as a Service Coordinator. Supervisors are responsible for providing ongoing supervision and training to staff.

- Must meet with each of the waiver participants served by the SC staff before approving the RSP, at least annually
- Must meet with their staff monthly
- Must review and sign all service plans
- May maintain an active caseload not to exceed twenty-five (25) waiver participants

Recordkeeping

Establishing and Maintaining Participants Records

Policy:

- To ensure that individual participant's case records are complete according to procedure, accurate and reflective of the person's total services. Maintaining records in a secured environment when they are not in use;
- Preventing exposure of information when records are in use;
- Identifying all information transmitted from one location to another as "confidential" in an appropriately secured manner;
- Obtaining prior authorization from the appropriate supervisory staff before records are taken outside the agency, and the return of records within one (1) business day;
- Properly informing applicants/participants of record collection procedures, access, utilization and dissemination of information;
- Specify procedures related to employee access to information; and
- Specify the disciplinary actions for violations of confidentiality statutes, regulations and policies.

Procedure:

The Service Coordinator shall maintain a file for each participant that includes:

1. The Application Packet for all funding sources relating to the TBI Waiver Service.
    - If the Service Coordinator was not involved in the development of the Application Packet for the TBI Waiver, a copy must be obtained from the RRDS or the previous Vendor.
2. The original and all subsequent UAS/Screens
3. Initial Service Plan packet and all Revised Service Plans (RSPs) completed by current vendor including all Individual Service Reports and Detailed Plans.
4. All Addendums

5. Initial Notice of Decision (NOD) and all Notices of Decision since becoming provider.
6. Summaries of all Team Meetings/Service Plan review meetings.
7. Participant's Rights and Responsibilities original/subsequent since becoming a provider signed and dated.
8. Provider Contact Lists
9. Documentation of the provision of Service Coordination services
10. Documentation of all contacts with:
    - The participant
    - Family and informal supports
    - Providers of waiver services
    - Providers of non-waiver services
    - Regional Resource Development Specialists
    - Local Departments of Social Services
    - RN Evaluator and DOH Waiver Management Staff
11. Plans for Protective Oversight (PPO)
12. Records will reflect the last 24 months (2 years) of service provision to the individual, with the Initial Service Plan packet retained in the active binder indefinitely. Alternate records will be safely stored for a period of 6 years, plus the current year beyond the active binders.
13. All completed Insurance, Resources and Funding Information Forms
14. Documentation of proof of the participant's current Medicaid eligibility each time the RSP is submitted to the RRDS
15. Documentation of Release of Information forms
16. Transportation records obtained and submitted with each RSP.

1. Detailed Plans

Each waiver provider (except for Service Coordination) must develop a Detailed Plan for each waiver participant they are serving. The Detailed Plan identifies the participant's goals for each waiver service and describes the interventions to be provided to assist the participant to achieve his/her goals. The Detailed Plan is an essential component of a participant's efforts to remain in his/her community of choice.

The development of the Detailed Plan begins with the provider interviewing the participant to establish the specific goals he/she wants to achieve through this service. Once these goals are established, information must be obtained regarding the participant's current level of functioning. This will occur through discussions between the provider, the participant and others. If the individual has been in a facility or has been receiving services in the community, it is essential to obtain any formal assessments which have been completed including discharge summaries. This may require discussions with staff from nursing homes, hospitals, certified home health agencies and licensed home care service agencies. The method for gathering baseline information may vary according to the particular waiver service. In addition, the provider may utilize information received from these assessments to complete the Detailed Plan. The provider is responsible for completing a thorough evaluation of the participant's basic skills and abilities related to the selected goals.

Even after the Detailed Plan has been developed, there must be an ongoing process where providers must objectively and constantly review the Plan's goals with the participant. This allows the provider to fully evaluate the participant's progress, address any areas of concern and make needed revisions to the Detailed Plan.

The Detailed Plan should include three components:

i. **Milestones** - Milestones are defined as component, intermediate steps which must be accomplished to achieve a larger goal. For example, a participant's goal is to resume participation in preparing meals for his/her family. A milestone would be established through the planning, preparing and serving of dinner for three consecutive days.

ii. **Interventions** - Once milestones are established, the provider determines what interventions will assist the participant to achieve the milestones and, eventually, the selected goal. A thorough understanding of the participant's unique strengths, deficits, interests and abilities will help guide the provider in the development of interventions. For example, ILST would work with the participant on the steps needed to plan a meal. This would include creating a menu, making a shopping list for items needed to make the meal, and purchasing needed items.

iii. **Timeframes** - Timeframes include the frequency and length of the interventions and how long the participant and provider expect it will take for the participant to reach the selected goal. It is essential to set realistic timeframes to determine the success of an intervention and the stated goal. It can be equally important to assist a participant to recognize that a particular goal may not be obtainable but that the outcome of the goal can be accomplished through another means. For example, if a participant is not successful in achieving the milestone of planning and preparing one meal within the designated timeframe, re-evaluation of the milestone, interventions and/or timeframe must occur. This includes determining what other means can be utilized to help the participant accomplish the goal of participating in meals with his/her family.

2. Documentation of Encounters

The provider must document each face-to-face encounter with the participant as required by Medicaid for reimbursement. This documentation should provide a measure of how effective the intervention has been in supporting the participant in meeting their goals. It should contain a clear description of the staff's action, the participant's response to that action and progress toward the goals /milestone. Documentation of this encounter must include:

- the date,
- the location,
- the time and
- a description of the services provided, which are related to the goals established in the Detailed Plan. For Service Coordination encounters, satisfaction with each service will be accessed, along with any significant events, health/safety issues, and follow-up actions needed on behalf of the participant.

This information must be recorded as soon as possible (i.e., within 72 hrs.) after each contact and reviewed for completeness each month.

In addition to documenting encounters, providers must keep case notes that reflect:

- communication with participants' family, friends, waiver and non-waiver providers;
- health and welfare issues and follow-up; and
- concerns expressed by the participant or others and the actions taken to address them.

All providers are responsible for maintaining open communication with other providers when concerns or changes with the participant occur that potentially affect the provision of services. However, each provider must be respectful of the participant's right to privacy and confidentiality regarding the sharing of information and have in place policies and procedures that support this.

3. Individual Service Reports (ISR)
The ISR (refer to Appendix C – form C.16) is an opportunity for the provider to describe its activities during the past year (unless there are changes required) and to describe the participant's future goals.

Waiver service providers are required to submit an ISR to the Service Coordinator (SC) for inclusion in each Revised Service Plan (RSP). The ISR must be submitted to the participant's SC at least six (6) weeks prior to the end of the NOD period or at the Team Meeting held to discuss the development of each RSP. Failure to provide a timely ISR may result in provider Vendor Hold.

The following waiver service providers are required to submit ISR(s):

- Home and Community Support Services
- Independent Living Skills Training Services
- Positive Behavioral Interventions and Supports
- Community Integration Counseling
- Structured Day Program Services
- Respite Services
- And Service Coordination

The ISR is directly related to the Detailed Plan and ongoing documentation of encounters with the participant. The Detailed Plan sets the overall design of the interventions to be implemented. The notes regarding ongoing interactions with the participant provide the information necessary to complete the ISR.

The ISR documents the progress of the participant in relation to the provided service, describes if there is a need for the continuation of the service and represents the provider's request for continued approval to provide the service. The completion of the ISR relies on a thorough review of the Detailed Plan by the provider with the participant.

To justify re-approval/continuation of a service, the ISR must clearly describe how the continuation of this service is needed to assure health and welfare of the participant in the community.
The ISR must identify responses to the following questions:

- What were the participant's goals identified in the current RSP?
- What interventions were used to address goals?
- How successful were the interventions utilized and what progress has been made towards the goals?
- Did any barriers occur in the progress towards meeting the goals?
- What will be the goals, expected interventions and outcomes for the next six (6) months?
- What are the recommendations for frequency and duration of this service?
- Why is this service needed to assure health and welfare in the next service plan?

Providers of the following waiver services are not required to complete an ISR for these services:

- Assistive Technology (AT);
- Community Transitional Services (CTS);
- Environmental Modifications Services (E-mods); and
- Service Coordination (Capital Region RRDC)

Informing Participants of their Rights including HIPAA

Policy:

Individuals receiving services through Catholic Charities Disabilities Services have the same legal rights and responsibilities guaranteed to all other individuals under the federal and state constitutions and federal and state law, unless such rights are modified by court order. The rights of individuals receiving services are attached. Catholic Charities Disabilities Services Service Coordinators and other qualified personnel will inform individuals of their rights on an annual basis; as well as the procedure of protecting their personal health information (HIPAA) at the time of intake. Every 6 months TBI Waiver participants will be presented the Waiver Rights & Responsibilities.

Procedure:

At the time of intake into Catholic Charities Disabilities Services, the Intake Service Coordinator will review the TBI Waiver Participant's Rights & Responsibilities (R & R), CCDS' R & R, as well as the HIPAA information with the individual and their advocate.

The individual and a witness will sign both the Rights form as well as the HIPAA acknowledgement form.

The completed Rights form will be attached to the Initial Service Plan as well as all subsequent revised plans. Rights forms are completed for TBI Waiver Participants, once every 6 months.

The HIPAA form will be filed in individual's record. The HIPAA form is only completed once, at the time of intake unless requested by the individual served or potential service providers.

The CCDS R & R will be completed annually and filed under program requirements in the individual's record.

Waiver Participant's Rights and Responsibilities

Every waiver participant is assured certain rights and must agree to certain responsibilities related to the waiver program. As part of the approval process, the potential participant is presented with a copy of the Waiver Participant's Rights and Responsibilities for the TBI waiver by the Service Coordinator.

The Service Coordinator is responsible for explaining the rights and responsibilities of being a waiver participant to the individual and/or legal guardian. These rights and responsibilities should be reviewed during the development of the application and semi-annually, and any time the Service Coordinator is aware that the participant does not understand his/her rights or responsibilities. The Waiver Participant's Rights and Responsibilities must be signed and dated by the applicant and/or legal guardian. The Service Coordinator gives a copy to the participant.

The Waiver Participant has the Right to:

1. Be informed of his/her rights prior to receiving waiver services;
2. Receive services without regard to race, religion, color, creed, gender, national origin, sexual orientation, marital status, or disability;
3. Be treated as an individual with consideration, dignity and respect including but not limited to person, residence and possessions;
4. Have services provided that support his/her health and welfare;
5. Assume reasonable risks and have the opportunity to learn from these experiences;
6. Be provided with an explanation of all services available in the TBI waiver and other health and community resources that may benefit him/her;
7. Have the opportunity to participate in the development, review and approval of all Service Plans, including any changes to the Service Plan;
8. Select service providers and choose to receive additional waiver services from different agencies or different providers within the same agency without jeopardizing participation in the waiver;

9. Request a change in services (add, increase, decrease or discontinue) at any time;
10. Be fully informed of the process for requesting an Informal Conference and Fair Hearing upon receipt of a Notice of Decision or at any time while on the waiver.
11. Be informed of the name and duties of any person providing services to him/her under the Service Plan;
12. Have input into when and how waiver services will be provided;
13. Receive services from approved, qualified individuals;
14. Receive from the Service Coordinator in writing a list of names, telephone numbers, and supervisors for all waiver service providers, the RRDS, and TBI Complaint Hotline;
15. Refuse care, treatment and services after being fully informed of and understanding the potential risks and consequences of such actions;
16. Have his/her privacy respected, including the confidentiality of personal records, and have the right to refuse the release of the information to anyone not authorized to have such records, except in the case of his/her transfer to a health care facility or as required by law or Medicaid requirements;
17. Submit complaints about any violation of rights and any concerns regarding services provided, without jeopardizing his/her participation in the waiver and not being subject to restraint, interference, coercion, discrimination or reprisal as a result of submitting a complaint;
18. Receive support and direction from the Service Coordinator to resolve his/her concerns and complaints about services and service providers;
19. Receive additional support and direction from the RRDS, DOH Waiver Management staff as desired or in the event that his/her Service Coordinator is not successful in resolving concerns and complaints about services and service providers;
20. Have his/her complaints responded to and be informed of the final resolution of the investigation;
21. Have his/her service providers protect and promote his/her ability to exercise all rights identified in this document;
22. Have all rights and responsibilities outlined in this document forwarded to his/her court appointed legal guardian or others authorized to act on his/her behalf; and
23. Participate in surveys inquiring about your experiences as a TBI waiver participant. This includes the right to refuse to participate in experience surveys without jeopardizing your continued participation in the TBI waiver program.

Waiver Participant's Responsibilities

The participant is responsible for:

1. Working with the Service Coordinator to develop/revise his/her Service Plan to assure timely reauthorization of the Service Plan;
2. Working with his/her waiver providers as described in his/her Service Plan;
3. Following his/her Service Plan and notifying his/her Service Coordinator if problems occur;
4. Talking to his/her Service Coordinator and other waiver providers if he/she wants to change his/her goals or services;
5. Providing to the best of his/her knowledge complete and accurate medical history including all prescribed and over-the-counter medications he/she is taking and understanding of the risk(s) associated with his/her decisions about care;
6. Informing the Service Coordinator about all treatments and interventions he/she is involved in;
7. Maintaining his/her home in a manner which enables him/her to safely live in the community;
8. Asking questions when he/she does not understand his/her services;

9. Not participating in any criminal behavior. He/she understands that, if he/she does, his/her service provider(s) may leave, the police may be called and his/her continuation in the waiver program may be jeopardized;
10. Reporting any significant changes in his/her medical condition, circumstances, informal supports and formal supports to his/her Service Coordinator;
11. Providing accurate information related to his/her coverage under Medicaid, Medicare or other medically-related insurance programs to your Service Coordinator;
12. Notifying all providers as soon as possible if the scheduled service visit needs to be rescheduled or changed;
13. Notifying appropriate person(s) should any problems occur or he/she is dissatisfied with services provided; and
14. Showing respect and consideration for staff and their property.

Documenting Participant Contacts and Service Notes
Policy:
Catholic Charities Disabilities Services will maintain a comprehensive record of services of each individual receiving Service Coordination services.

Procedure:
1. Each participant will have a section in their Service Coordination binder for Service Notes/Case Notes.
2. The Service Coordinator will maintain a comprehensive chronologically written record of services and activities provided by the Service Coordinator as well as the participants' response to these services.
3. The Service Coordinator Case Notes must contain the following:
   - The person's name
   - A specific note indicating the monthly face to face
   - The three-part date and description of the service or conversation held on behalf of the participant
   - The participant's stated satisfaction or dissatisfaction with the service and any follow up taken
   - Any specific changes in events in the person's life
   - Concerns of health and safety
   - A written indication of the Service Plan review at least annually as well as any pertinent information and the Service Coordinator notes as important to the participant

   Case notes are signed and dated by the providing Service Coordinator.
4. The monthly face to face meeting is to be highlighted.
5. Case notes are to be filed in the participant's record monthly.
6. All records will be maintained for a period of 6 years plus the current year. The record can be archived in the on-sight active archive file room.

Intake and process for completing ISP, RSP and Addendum
Policy:
Catholic Charities Disabilities Services will ensure that all individuals who receive services from Catholic Charities Disabilities Services are deemed eligible for services and are provided with prompt and accurate opening of their cases, thus allowing for quicker access to necessary and desired services.

Procedure:

1. All referrals will be made to the Director/ Associate Director of the Service Coordination Program (Individualized Community Services department).
2. The Intake Service Coordinator or the Associate Director or designee will ensure eligibility either through the initial paperwork received from the RRDC or through obtaining records with participant consent (i.e., medical, neuropsychological, rehabilitation records).
3. The Director/ Associate Director or designee, will assign the person to a qualified Service Coordinator who will receive the case and work with the individual and their family/advocate. When the intake is complete, the assignment to a Service Coordinator will be based on whether or not they have an opening, keeping in mind appropriate matches and qualifications necessary to perform the duties of Service Coordination.
4. The Service Coordinator will complete the initial intake with the individual and their family/advocate.
5. Each referral will be given equal opportunity for services without regard to race, color, creed, sex, national origin or disability.

The Service Plan

The development of the Initial Service Plan (ISP) is a complex process and a key responsibility of the SC. The development of the ISP begins upon acceptance of the applicant by his/her chosen Service Coordination provider.

All Service Plans must be person-centered and support the applicant's dignity, right to take risks and the right to fail while maintaining his/her health and welfare living in the community. Through direct interview and assessment, the SC must be able to acquire information needed to build an individualized and comprehensive plan. To accomplish this, multiple visits with the applicant by the SC may be required. The applicant may choose to include family, friends and others he/she selects to participate in the process. If the individual has a legal guardian he/she are present for the ISP development.

The Service Plan must reflect the applicant's strengths and abilities. It details all of the services and supports (e.g. informal supports such as family and friends) necessary to maintain the applicant in the community and prevent institutionalization, and the coordination of these services and supports. As information is collected for the Service Plan, the SC taking into account the efficiency of service utilization, must determine whether services are available through informal supports, non-Medicaid local, state and federally funded programs, Medicaid State Plan services, and/or Waiver services.

The SC must collaborate with Local Department of Social Service (LDSS) staff to have an understanding of the applicant's history, if any, of participation in Medicaid State Plan community-based services or adult protective services. This collaboration will further the SC understanding of the strengths and needs regarding the applicant's health and welfare if he/she is approved for the TBI waiver.

The SC discusses the need for non-waiver options with the applicant to ensure appropriate referrals are made. If the applicant is already receiving non-waiver services with the anticipation of continuing them if approved for the TBI waiver, the SC must obtain appropriate information from and regarding each of these services for inclusion in the ISP.

If the applicant's ISP indicates the need for Home and Community Support Services, Assistive Technology, Environmental Modifications, and/or Community Transitional Services, the Service

Coordinator must obtain, complete, and attach all applicable supporting documentation (e.g. HCSS assessment tools).

The SC works with the applicant to establish what services are needed. Upon selection of waiver service providers by the applicant, the SC is responsible to contact each waiver service provider to ensure the availability and ability necessary to provide the service(s). In addition, the SC coordinates the inclusion of non-waiver services. The SC must work collaboratively with the applicant, TBI and non-waiver providers and others to prepare the most accurate and complete Service Plan for submission to the RRDC. Open communication assists the SC in establishing a projected weekly schedule of all services (including days, times and who will provide) with input from the applicant. The schedule also includes the availability of informal supports.

Once the ISP is reviewed with/by the applicant, he/she is asked to sign the document indicating understanding of its contents and purpose as written. The SC then submits the completed ISP as part of the Application Packet to the RRDC for review.

Service Plans are expected to evolve as the participant experiences life in the community, requests revisions, and experiences significant changes in his/her condition, or as new service options become available.

Types of Service Plans

The following is an explanation of the different types of Service Plans used in the TBI waiver.

1. Initial Service Plan (ISP)

The ISP is developed when an individual is applying to become a waiver participant. The ISP is a collection of personal, historical, medical/functional and social information about the applicant gathered through interview and assessment of the individual by the Service Coordinator (SC) and others. It is the primary component of the Application Packet. The ISP provides justification for the individual's participation in the TBI waiver. It describes the reason TBI services are needed to ensure the individual's health and welfare while in the community.

The focus of the ISP is on the individual, reflecting his/her choices and needs that support the individual's health and welfare while in the community. This includes information regarding significant relationships, current informal and community supports, desired living situation, and recreation or community inclusion-time activities. The ISP must also contain a description of the individual's strengths and limitations, including any cognitive, behavioral or physical concerns.

The ISP also details services necessary to maintain the individual in the community. A description justifying why the services are needed to allow for transition from a nursing home into the community or to prevent nursing home placement from occurring is also included. For an applicant presently in an institution, the ISP must include current assessments and/or summaries of all services provided by the facility, including relevant medical reports.

2. Revised Service Plan (RSP)

The RSP is developed through a collaborative effort between the participant, individual(s) selected by the participant to participate in the development of the RSP, the SC, current TBI waiver service providers, non-waiver providers, and others as appropriate. The focus of the RSP remains on the individual, reflecting his/her needs and choice of services that continue to support safe and successful community living.

The RSP is required in the following situations:

- Annually, if the participant chooses to continue waiver services;
- When a participant is absent from the community (e.g. extended institutionalization) where upon return to the community the individual's needs have significantly changed, requiring revision of the Service Plan;
- Any time there is a need for a significant change in the level or amount of services (e.g. a decrease/increase in the participant's abilities, a change in the participant's living situation, a participant wants to make a significant change in his/her Service Plan, or there is a major change in the availability of informal supports); and
- When a participant relocates from one region to another.

The RSP must contain a review of the participant's previous months in the waiver and identify the plans and goals for the next year. The RSP details services necessary to maintain the individual in the community and prevent nursing home placement.

3. Addendum to the Service Plan

The Addendum to the Service Plan is developed by the SC in collaboration with the participant and individual(s) selected to participate in the process and specific service provider(s) when there is only a minor change needed in the amount, type, or mix of waiver services to an existing Service Plan. (e.g. a participant wishes to increase/decrease the amount of time at a Structured Day Program).

Plan for Protective oversight (PPO)

The PPO indicates all key activities that directly impact the health and welfare of the participant and clearly identifies the individual(s) responsible for providing the needed assistance to the participants in the event of an emergency or disaster.

The PPO must be completed by the SC with the applicant during the development of the ISP. The PPO must be signed and dated by the applicant and SC and all individuals listed as Informal Supports to the waiver applicant. It is attached with the ISP packet and sent to the RRDC for review and signature. A copy of the PPO must be provided to the participant by the SC to be maintained in an easily accessible location of the participant's choice within his/her home. A copy is also provided to each waiver service provider listed in the ISP.

The PPO must be redone by the SC with the participant each time an RSP is developed for submission with the RSP packet to the RRDC for review. The SC, participant, and all individuals listed as Informal Supports to the participant must sign the PPO. A final copy of the PPO is distributed by the SC to the participant to maintain in an easily accessible location of the participant's choice within his/her home. A copy is also provided by the SC to each waiver service provider listed in the RSP.

The PPO must be reviewed by the SC with the participant at each Addendum. If there are any changes, a new PPO must be completed and signed by the participant, SC and any individuals listed as Informal Supports to the participant. The PPO must be attached to the Addendum for submission to the RRDC for review.

Should any information in the PPO change in the interim, the SC is responsible for making updates at that time and acquiring signatures from the participant and any individuals listed as Informal Supports to the participant. The PPO must be sent to the RRDC for review and signature. If the participant's

situation has changed and he/she now has a legal guardian, the SC will request and obtain the guardian documentation. A copy of this guardian documentation is forwarded to the RRDC. The SC is responsible to communicate with the waiver service providers that the participant now has a legal guardian who they need to communicate with as needed. The SC does not forward the guardian documentation to waiver service providers, only to the RRDC as stated above.

Once reviewed and signed by the RRDS, a copy of the PPO signature page is returned to the SC, who distributes the completed PPO to the participant and any waiver service provider listed in the current Service Plan.

Coordination of Non-Waiver Services

In addition to the scheduling of waiver services, the SC must also identify and coordinate all non-waiver services deemed appropriate and necessary for the applicant. If the applicant is not currently receiving non-waiver services, the SC must work with him/her and all necessary partners to obtain any necessary referrals, assessments and approvals/authorizations.

If the applicant is currently receiving non-waiver services, the SC must work with him/her and all necessary parties to obtain any necessary referrals, re-assessment and re-approvals/re-authorizations for the potential continuation of these services.

It is the SC's responsibility to maintain a current understanding of the processes required to obtain necessary referrals, re-assessments and re-approvals for non-waiver services.

This includes understanding which services under Medicaid require a physician's order (e.g. personal care or private duty nursing) and re-approvals/re-authorizations (e.g. authorization from LDSS for personal care and/or prior approval from State DOH or the LDSS for private duty nursing). The RRDS and/or SC may identify that the applicant/participant requires the provision of skilled tasks. These tasks are not provided by TBI waiver services. They are potentially provided to Medicaid recipients under State Plan services through Certified Home Health Agencies (CHHA), Private Duty Nursing or the Consumer Directed Personal Assistance Program (CDPAP). When Service Plans include State Plan services, the SC must work closely with LDSS assuring there is no duplication of services and that roles and responsibilities are clearly defined.

Once all non-waiver services are identified, the SC must include them in the Projected Weekly Schedule of the ISP to ensure the coordination of services, preventing unnecessary overlap and/or gaps in services. The SC must clearly articulate the provision of service the provider is responsible for.

Scheduling of Waiver Services

Part of the work to develop an ISP is the scheduling of anticipated services that the applicant will receive. The Projected Weekly Schedule of All Services is a one (1) week schedule for twenty-four (24) hours-a-day indicating the type of the service being provided (e.g. ILST, CIC, informal supports, etc.) and the day(s), time(s) and frequency of each service in the Service Plan. The name of each provider agency must be documented in the Waiver Service and Cost Projection chart in the ISP. The name of Informal Supports and specific assistance provided are documented in the Current Supports and Services section of the ISP. The schedule should be flexible to allow for preferences and limitations of the applicant such as a limited attention span or reduced stamina, balanced with the availability of formal and informal supports. It should be designed to meet the goals and needs of the applicant, support the waiver's philosophy of choice, and provide for the health and welfare of the participant.

Once the ISP is approved by the RRDS and the applicant becomes a participant, the established frequency and duration of waiver services must be adhered to unless prior approval is given by the RRDC following a request to increase or decrease services.

Negotiations for changes in time will include the waiver participant, SC, and impacted providers of waiver and non-waiver services.

The Service Plan must document any situations where two services will be provided at the same time to ensure consistent and effective service provision; situations must be clinically justified and time limited. Example: When an Independent Living Skills Training (ILST) provider is training Home and Community Support Services (HCSS) provider to assist a participant in a specific task or when the Positive Behavioral Interventions and Supports (PBIS) provider is in the process of developing the PBIS Detailed Plan must observe a participant's behavior at the Structured Day Program (SDP). The overlap of services must be justified and documented in the Service Plan in order for both services to be reimbursed.

Services may be rescheduled if the participant is unable to participate or the provider is not available. When the participant requests that a service be suspended for a day or more, it is the responsibility of that participant and/or informal support to notify the SC who, in turn notifies the providers. If the participant notifies the provider(s), he/she must also notify the SC.
A provider should notify the SC when a participant repeatedly refuses a service. The SC should review the Service Plan with the participant and provider to determine if it needs to be revised to more accurately reflect the goals and abilities of the participant. Revisions to the schedule should allow enough time for the provider to make the necessary arrangements. When a participant refuses significant services, it may be necessary to discontinue the individual from the waiver.

Submission of the Application Packet and ISP
Once the potential participant selects a SC who agrees to work with him/her, the SC has sixty (60) calendar days to submit a completed Application Packet, including the ISP, to the RRDC.

Once the ISP is completed, the SC must review it with the applicant and asks the applicant to sign the document.

The SC must have the SC supervisor review and sign the completed Service Plan prior to submission to the RRDC for review. This provides another level of professional review identifying any inconsistencies or problems in the Service Plan which could impede the approval process.

The SC submits the Application Packet with the ISP to the RRDC for review. In addition to the ISP, the Application Packet includes the following documents:

- Freedom of Choice form;
- Application for Participation form;
- Documentation of a Traumatic Brain Injury (examples: hospital/rehab records; neurological and/or neuropsychological evaluations).
- Verification from Medicaid Eligibility Verification System (EMEDNY) regarding Medicaid coverage that supports community based long term care services;
- Service Coordinator Selection form;
- Provider Selection forms- signed by the Applicant and provider;

- A PRI and UAS SCREEN completed by a certified assessor within ninety (90) days prior to the submission of the Application Packet and ISP to the RRDC;
- Plan for Protective Oversight (PPO);
- Waiver Participant's Rights and Responsibilities form; and
- Any Description and Cost Projection form(s) and HCSS assessment form, if applicable completed by the provider agency and submitted by the SC.

There may be instances when a delay is expected in submitting an Application Packet to the RRDC. The SC must maintain consistent and open communication with the RRDC if this is indicated. Depending on the circumstances of the delay, the RRDS may choose to grant an extension of the sixty (60) calendar day deadline. Some examples of this are: establishing a residence, unexpected hospitalization, nursing home admission, or indecisiveness on the part of the participant regarding receipt of waiver services. In addition, length of time residing in a nursing home may require a longer period of time to establish a safe discharge and set up appropriate services.

If the SC does not meet the sixty (60) calendar day time frame for submission of the ISP packet or does not meet the conditions of the approved extension period, the SC and Service Coordination agency supervisor receives written notification from the RRDC indicating that the Application Packet is past due and must be submitted within the next thirty (30) calendar days. If the SC does not comply with the thirty (30) calendar day time line, the RRDC will send the SC agency supervisor written notification stating that due to non-compliance, the agency may no longer serve that applicant. The RRDS meets with the applicant to select another Service Coordination agency.

If late submission of Application Packets becomes a repeated problem for an agency, the RRDC will notify DOH of this problem. DOH will send a Letter of Vendor Hold via certified mail to the Service Coordination agency Executive Director indicating the intent to close referrals of new participants until a written plan of action is submitted and approved by DOH. If this problem is not corrected, DOH will begin the provider disenrollment process by sending the Service Coordination agency's Executive Director a Notice of Pending Disenrollment via certified mail.

Review and Determination Process for the ISP

Upon receipt of the Application Packet, and ISP, the RRDC has fourteen (14) calendar days to review the information and make a final determination.

The RRDC completes the RRDS Initial Service Plan Review form while reviewing the ISP to determine that:

1. the individual is in need of waiver services;
2. Medicaid eligibility has been verified;
3. the individual meets the appropriate age requirement;
4. the individual has a documented Traumatic Brain Injury;
5. the PRI/UAS SCREEN is current, and identifies the applicant as needing a nursing home level of care;
6. the ISP is reasonable given the context of the participant's stated goals and needs;
7. all available informal supports and non-waiver services are utilized wherever appropriate;
8. waiver services will be used appropriately, and in a reasonable and effective manner;
9. the services described in the ISP will maintain the individual's health and welfare;
10. the overall plan and goals for each waiver service describes the activities that each service will provide towards the accomplishment of the participant's goals;

11. the PPO is completed, signed and reasonable;
12. all other forms included in the Application Packet are completed and signed by the applicant;
13. the waiver applicant has signed the Initial Service Plan; and
14. projected costs for Medicaid services fit within the regional aggregate Medicaid cap established by DOH.

The RRDS will request review of an Application Packet, included in the ISP by the Nurse Evaluator if the needs of that applicant appear to be medically complex.

The RRDS must send all Service Plans over a projected $300 per day to DOH, with a copy of the RRDS Service Plan Review form attached for further review and recommendations. DOH must return the Service Plan with recommendations to the RRDC within three (3) business days.

If there are any discrepancies/concerns regarding the Service Plan, the RRDS must return it to the SC for correction or additional information. This is documented on the RRDS Initial Service Plan Review form.

The SC has fourteen (7) calendar days to respond to the RRDS's request for additional information or corrections and resubmit the Service Plan to the RRDS for final review and determination. Prior to resubmission of the ISP, the SC must present the revised plan to the applicant for review and signature.

Total turnaround time for waiver eligibility determination is expected to be less than ninety (90) days from the time of Service Coordination selection to final determination by the RRDC.

Upon final determination, the RRDS signs the RRDS Service Plan Review form, ISP and PPO.
If approved, the applicant is acknowledged as a 'participant'. The RRDS must complete the Notice of Decision (NOD) - Authorization and distributes it to the participant and all others listed on the NOD. The SC must provide a copy of the ISP and PPO to the participant. The SC communicates the authorization and the effective date to the facility (e.g. nursing home, hospital, etc., if applicable) and all non-waiver providers involved in the ISP. The SC also sends a copy of the approved ISP and PPO to all TBI waiver service providers responsible for delivery of the services and items identified in the ISP.

If the RRDS believes that the applicant will be denied for the TBI waiver program, he/she must contact DOH Waiver Management Staff (WMS) to discuss the reasons for this decision. Following this discussion, if the applicant is denied, the RRDS completes and sends a NOD- Denial of Waiver Program to the applicant and SC. The SC in consultation with the RRDS will provide alternative referral options (e.g. names and phone numbers of other LTC programs, etc.) to the denied applicant. The SC will notify the nursing home, if applicable, and all waiver and non-waiver providers involved in the development of the ISP of the denial decision.

Waiver Contact List
The SC will provide to each participant a Waiver Contact List, containing a current listing of his/her waiver service providers as listed in the ISP. This list includes the services provided, names of the provider agencies, names of the persons providing the services and their phone numbers, names of their supervisor, and the supervisor's phone number. Also included is contact information for the RRDC and TBI Complaint Line.

Waiver Service Providers are responsible for contacting the SC when contact information pertinent to the participant changes. The SC provides a copy of the updated list of services and phone numbers to the participant and to all waiver service providers listed in the ISP.

The SC retains a copy of the most updated contact list in the participant's file.

This process must be repeated each time a new waiver service is started and when there is a permanent change in the person providing the service or provider agency; with the submission of a Revised Service Plan; or at the time of submission of an Addendum. The SC must review the Contact List to assure it is correct and up-to-date. If changes are warranted, the SC will make needed updates and redistribute the contact list.

Implementation of the Approved Service Plan
In consultation with the SC, the RRDS must establish the effective date for services to begin and notify the SC. The SC must then contact the participant, waiver service providers, non-waiver providers, and other necessary parties as appropriate and arrange for services to begin.

Each approved waiver service provider must meet with the participant and anyone else selected by the participant to complete a Detailed Plan.

The Detailed Plan includes:

- all assessment(s) conducted by the waiver service provider;
- participant's goals as it relates to the waiver service that is the subject of the Detailed Plan;
- milestones needed to meet the goals of the Detailed Plan;
- interventions needed by the waiver service provider to assist the participant in meeting his/her goals; and
- timeframes in obtaining the participant's individualized goals.

Waiver service providers must communicate with each other, informal supports and non-waiver providers at all times, especially when there is an overlap in the provision of services to the participant in achieving his/her milestone and/or goal. An example of this is the provider of Positive Behavioral Interventions and Supports (PBIS) communicating with other waiver service providers on methods of working with a participant with behavioral issues.

If at any time a waiver participant or waiver service provider determines the need to change the amount, frequency or duration of services approved in the ISP, the SC must be notified. No changes may be made by the waiver service provider until receiving notification from the SC following approval of an Addendum or RSP by the RRDC, as appropriate.

Waiver service providers must recognize that Detailed Plans are ever-changing as the needs of the participant change. Therefore, re-assessments are a critical element of the Detailed Plan.

Services via Telehealth

Policy:
Catholic Charities will allow for provision of TBI Service Coordination supports via telehealth if it is the expressed desire of the participant.

Procedure:
If a participant chooses to receive some or all of their supports via telehealth, this will be discussed and documented during planning meetings or outside meeting times when needed.
When SC services are provided via telehealth modality, the SC will make a notation of this in the service note.

Monthly Billing Requirements for Service Coordination Provided Virtually (telehealth):
When TBI Service Coordination is provided virtually or via telehealth, each billable contact must be at least fifteen continuous minutes in duration. This minimum requirement is intended to support the delivery of meaningful, person-centered Service Coordination and ensure that telehealth contacts are sufficient duration to address the participant's identified needs. Service Coordinators providing services via telehealth must maintain documentation that supports the monthly billing claim and demonstrates compliance with waiver and Medicaid requirements. Documentation for each telehealth contact must include the date of service coordination activities performed and their relationship to the participant's goals and needs.

Ongoing Review of the Service Plan
The SC should regularly review services with the participant. This review is a natural component of the meetings between the participant and SC. The SC must meet with him/her face-to-face at a minimum once a month. It is expected that at least quarterly, the face-to-face visit will be made in the participant's home.

These visits should focus on all aspects of the participant's life, including:

- Satisfaction with the performance of providers and informal supports;
- Satisfaction with living situation;
- Adequacy of supports and services;
- Provision of the waiver services per the approved Service Plan ensuring that at a minimum one waiver service is provided per month;
- Sufficient opportunities to participant in community activities;
- Achievement of goals related to waiver services;
- Changes in function and behavior; and
- Changes in priorities or goals.

Any issues identified must be addressed by the SC with the provider, other necessary parties and/or RRDC, as appropriate.

Other events that may trigger a Service Plan review include:

- The participant requests a change in services or service providers;
- There are significant changes (improvement or decline) in the participant's physical, cognitive, or behavioral status;
- A new provider is approved for the TBI waiver and the participant is interested in either changing to that provider or adding a newly available service;
- The expected outcomes of the services are either realized or need to be altered; or
- Notification from a non-waiver provider of the need to change amount, frequency and/or duration of services.

In addition, review of the Service Plan is conducted through Team Meetings held with the participant and others involved in the Service Plan (refer to Submission of Revised Service Plans/Team Meeting below).

For plans that include one or more non-waiver services, the review of the plan must include timely outreach to and coordination with all involved parties (e.g. review of plans including personal care, certified home health agency, or private duty nursing must be considered with those providers and the agencies responsible for approving/authorizing services).

Development of the Addendum
Requests for changes to the Service Plan may come from the participant, the SC, other waiver service providers or other involved parties. The SC is responsible for working with the participant and anyone chosen by the participant to participate in the development of the Addendum.

In the case of an emergency, the SC must contact the RRDC for immediate approval to increase or add a waiver service. In these emergency cases the RRDS may give verbal approval to the SC. All communication between the RRDS and the SC must be documented. The SC then has two (2) business days to develop the Addendum and submit it to the RRDC.

Once the Addendum has been written by the SC, it must be reviewed and signed by the participant for submission to the RRDS for review and determination.

Submission of the Addendum
The SC will submit to the RRDS the completed and signed Addendum and a copy of each of the following documents:

- Waiver Contact List, if revision were necessary;
- A new PPO, if revisions were made which impact the PPO;
- ISR, only if a waiver service is stopped;
- Functional assessment if it is the basis of the Addendum (e.g. ILST, PBIS, etc.);

Review and Approval Process for the Addendum
The RRDS must review the Addendum to determine the need for changes in the service(s). If the Addendum increases the daily rate of the Service Plan to exceed $300/day, the Addendum must be reviewed by the DOH. DOH sends recommendations back to the RRDC within three (3) business days.

The RRDS will complete the RRDS Addendum Review form. Upon determination on the Addendum, the RRDS will distribute the appropriate NOD to the participant and other entities listed on the NOD form. The one year approval period of the Service Plan remains in effect.

If an Addendum to the Service Plan is denied by the RRDS, the SC must work with the participant to find an alternative solution, if possible. Technical assistance from the RRDS may be requested at any time.

A copy of the Addendum is provided to the participant and waiver service providers involved in the change.

Development of the RSP
The SC works with the participant and anyone he/she selects to participate and other necessary parties (ex., Waiver providers) in the development of the RSP. It is a time when the activities of the current

service plan period are reviewed to assess the participant's current status and to determine whether goals have been met successfully. The continued need for participation in the waiver program to avoid nursing home placement is also determined by the team.

The SC coordinates a date, time and location for the Team Meeting/RSP Review with the participant, all required waiver service providers, other necessary parties, and anyone else that the participant chooses to have attend. This meeting should be held eight (8) weeks prior to last day of current Service Plan period, to allow enough time to modify the plan and obtain Individual Service Reports (ISRs) from all the Waiver providers.

It is essential that all proposed RSPs be submitted to the RRDS by the SC at least thirty (60) calendar days prior to the end of the current Service Plan period for review and final decision. This is necessary to prevent delays in service which would adversely affect the health and welfare of the participant.

To ensure this is done, the SC must:

1. work with the participant to arrange for and facilitate a Team Meeting that must be held approximately eight (8) weeks prior to the end of the current Service Plan period to develop the proposed RSP. Attendees include the participant, legal guardian and anyone invited by the participant, waiver service providers and other non-waiver providers involved in the Service Plan. The Team Meeting provides an opportunity to discuss issues that cut across services and discuss/resolve concerns regarding health and welfare; and
2. Receive all current required waiver service provider's ISRs at the time of the Team Meeting or soon afterwards if modifications are needed. For the SC to appropriately develop the RSP, it is imperative that all current required waiver service provider ISRs are complete and submitted timely (within 2 weeks).

Information is gathered from ISRs submitted by each current required waiver service provider. Each ISR contains the information:

- Identifying each of the participant's goal(s) for this service which have been addressed during the current Service Plan;
- Identifying the interventions used to address each goal as described in the Detailed Plan;
- Identifying any progress made for each goal;
- Identifying any barriers to progress for each goal;
- Identifying the participant's goal(s), expected interventions and outcomes for this service in the next Service Plan;
- Providing recommendations for amount, frequency and duration of this service in the next Service Plan; and
- Explaining why this service is necessary to assure health and welfare in the next Service Plan.

The SC also uses information from the current Service Plan, including Addendum submitted during the Service Plan period. For new services, the SC must collaborate with the provider(s) selected by the participant to assure appropriate documentation of information into the RSP, including the justification for the new service.

For plans that include non-waiver service providers, the review of the plan must include timely outreach to and coordination with all non-waiver providers identified in the Service Plan (e.g. review of plans

including personal care, certified home health agency, or private duty nursing must be considered with those providers and the agencies responsible for approving/authorizing services).

The SC must discuss any proposed changes to the Service Plan with the participant and the individual(s) who participated in the development of the Revised Service Plan.

Once the RSP is completed, the SC must review it with the participant. The RSP must be signed by the participant or participant's legal guardian to indicate that the participant understands its contents and purpose as written.

The SC must have the SC supervisor review and sign the completed Service Plan prior to submission to the RRDS for review. This provides a level of professional review identifying any inconsistencies or problems in the Service Plan which could impede the approval process.

As previously stated, the SC submits the completed and signed RSP and any required documentation to the RRDC for review at least thirty (60) calendar days prior to the end of the current Service Plan period.

Delinquent Individual Service Reports (ISR) From Waiver Service Providers

- Waiver service providers are responsible to submit their ISR at least six (6) weeks prior to the end of the current Service Plan or at the Team Meeting to the SC to avoid interruption of service to the participant
- At the Team Meeting, if a waiver service provider determines that changes need to be made to the ISR to better reflect the participant's needs, that waiver service provider may request up to 2 weeks (given that ISR is received 6 weeks prior to NOD expiration) to revise and resubmit the ISR to the SC. In some situations an ISR can only be completed after decisions are reached during the Team Meeting.
- Each waiver service provider is responsible to develop and submit ISRs in accordance with timelines established in this section. Therefore, when a waiver service provider does not submit a timely ISR or does not communicate with the SC the need for additional time to submit an ISR, the SC must notify their supervisor for technical assistance. If no ISR is received 4 weeks prior to the end of the RSP period, the SC will notify the RRDC. They will send a late notice to the waiver service provider agency supervisor informing him/her that the ISR is delinquent, giving the provider agency seven (7) calendar days to complete and submit the ISR to the SC.
- If at the end of the seven (7) calendar days the waiver service provider agency has not complied with the submission of the ISR, the SC must contact the RRDC for further technical assistance. The RRDS notifies DOH WMS of the continued delinquency. DOH WMS sends a Letter of Vendor Hold via certified mail to the waiver service provider agency's Executive Director and SC Supervisor giving him/her seven (7) calendar days to submit the ISR. The letter includes notification that continued failure to submit the ISR will initiate the sixty (60) day Provider disenrollment process. Upon receipt of the ISR, the SC notifies the RRDC. Upon review and approval of the ISR by the RRDS, the RRDS notifies DOH WMS who may send the provider agency Executive Director a Letter of Vendor Hold termination.
- If the waiver service provider agency fails to comply within the seven (7) calendar days, the SC notifies the RRDC that no ISR has been received. The RRDS contacts DOH WMS. DOH WMS will issue the sixty (60) calendar day Notice of Pending Provider Disenrollment indicating the effective date of disenrollment.

- Upon receipt of the ISR, DOH will determine whether a notice will be issued by DOH terminating the disenrollment process. However, if there is an ongoing pattern of late Service Plan submission, DOH WMS has the right to continue the disenrollment process.
- In circumstances where the waiver service provider may not be able to submit the ISR on time, it is imperative that the waiver service provider maintains open communication with the SC regarding the reasons for late submission. The SC must contact the RRDC and communicate this delay. The RRDS makes a determination regarding a reasonable plan of action for submission of the ISR by the waiver service provider. The RRDS will send a Late Notice via certified mail to the waiver service provider agency supervisor including documentation of the expected action plan for submission of the ISR.
- The SC should proceed with the development of the Service Plan to maintain the timeline for submission to the RRDS for review.
- If the delinquent waiver service provider agency fails to comply with the action plan for submission of the ISR to the SC, the SC contacts the RRDS. The RRDS notifies DOH WMS of the waiver service provider's continued delinquency. DOH WMS will proceed with sending a Letter of Vendor Hold to the waiver service provider agency's Executive Director. If the agency fails to comply further, the RRDS will contact DOH WMS to begin Provider disenrollment procedures of the delinquent waiver service provider agency.

Submission of the RSP

The SC must submit the completed RSP packet to the RRDC for review. The RSP packet includes the RSP and the following:

- Written verification from the Medicaid Eligibility Verification regarding the participant's Medicaid status (ePACES);
- UAS SCREEN (a copy);
- ISRs from all appropriate waiver service providers;
- Provider Selection forms (if applicable);
- Plan of Protective Oversight (PPO) - newly written and signed;
- Waiver Participant Rights and Responsibilities form; and
- Description and Cost Projection forms and HCSS Assessment (if applicable)

Delinquent Submission of the RSP by the SC

Late submission of a RSP by the SC can result in the interruption of services to a participant and potentially lead to Vendor Hold or Disenrollment of the Service Coordination provider agency. A complete, acceptable RSP Packet must be submitted to the RRDS for approval at least thirty (30) calendar days prior to the end date of the current Service Plan.

When the SC is facing unforeseen circumstances that affect the submission of the Service Plan within the required timeframe, the SC makes immediate contact with the RRDC for technical assistance. A plan must be established that will prevent disruption of services to the participant, potential penalties to the Service Coordination agency, and billing concerns for all waiver service providers.

When a RSP Packet is not submitted to the RRDC by the SC at least thirty (30) calendar days prior to the end date of the current Service Plan, the following protocol must be followed:

1. Late Letter

A Late Letter will be sent to the Service Coordination agency supervisor by the RRDC any time a RSP packet is not submitted by the required timeframe (thirty (30) calendar days prior to the end of the

current Service Plan period). It informs the Service Coordination agency supervisor that communication with the RRDC is necessary and a plan to submit the RSP packet within seven (7) calendar days is expected. It further informs the supervisor that failure to comply will lead to the initiation of Vendor Hold process.

2. Vendor Hold

Vendor Hold restricts the Service Coordination agency from accepting any new TBI referrals. If the SC does not submit the RSP packet to the RRDC within seven (7) calendar days, the RRDC notifies DOH WMS. DOH will send a certified Letter of Vendor Hold to the Service Coordination agency supervisor and Executive Director informing him/her of continued non-submission of the RSP packet. The letter informs the agency that a completed and signed RSP packet must be submitted within seven (7) calendar days along with a plan of action to prevent further submission of late service plans. Failure to submit an acceptable RSP packet within this time frame constitutes breach of the Provider Agreement, leading to provider disenrollment.

If the NOD lapses, it is the responsibility of the SC to contact all waiver service providers involved in the RSP that billing for waiver services is now prohibited until the RRDC receives and approves the RSP packet.

If the Service Coordination agency submits an acceptable RSP packet to the RRDC within the seven (7) calendar day period, DOH may terminate the Vendor Hold process with a written notification to the agency.

3. Pending Provider Disenrollment

If the Service Coordination agency fails to comply with the terms of the Vendor Hold notification, the RRDC notifies DOH WMS. DOH WMS sends the Service Coordination agency Executive Director, Service Coordination Supervisor and SC a Notice of Pending Disenrollment via certified mail.

This notice informs the agency that due to continued non-compliance with the request for submission of the RSP packet, the agency will be disenrolled from the TBI waiver sixty (60) calendar days from the notice date. During this time Vendor Hold status remains in effect.
If at any time during this process the Service Coordination agency complies with the submission of the RSP packet and establishes a satisfactory plan of action to prevent delinquencies, DOH WMS may stop the disenrollment process.

Repeated late submissions of RSP packets will result in the initiation of the Provider disenrollment process whereby the Service Coordination agency will no longer be able to serve TBI waiver participants.

4. Provider Disenrollment

A Notice of Disenrollment is sent via certified mail by DOH WMS to the Service Coordination agency's Executive Director when the agency has failed to provide the requested information (e.g. RSP or ISR) and/or has not provided an acceptable plan of action. The letter specifies the final date of disenrollment. It informs the agency of the requirements for transitioning all waiver participants to new waiver service provider agency(s).

Review and Approval Process for RSP

The RSP review process must be completed by the RRDC within four (1) week. This includes RRDS review and, if necessary, return of the RSP to the SC for corrections and then resubmission to the RRDC for final review, issuance of the appropriate Notice of Decision, and sufficient time for implementation of RSP.

Upon receipt of the RSP packet, the RRDC uses the RRDS Revised Service Plan Review form while reviewing the RSP to determine if:

1. the individuals' health and welfare were maintained in the previous Service Plan and, if not what changes need to occur;
2. the participant continues to need waiver services;
3. Written verification regarding Medicaid coverage that supports community based long term care services is attached;
4. the UAS SCREEN is current, and reflects a nursing home level of care;
5. the RSP is reasonable given the context of the participant's stated goals;
6. all available informal supports and non-waiver services have been appropriately arranged and are utilized;
7. waiver services are being used in a reasonable and effective manner;
8. the services described in the RSP will maintain the participant's health and welfare;
9. the goals and preferences described in previous Service Plans have been the focus of the activities in the last six months;
10. the PPO is complete, signed and reasonable;
11. all other required forms (e.g. Cost Description and Projection forms, HCSS assessment form etc. if applicable) are completed, signed by the participant, and attached to the Revised Service Plan; and
12. the participant has signed the Revised Service Plan.

If the needs of the participant appear to be medically complex in nature, the RRDS will request additional review of the RSP by the Nurse Evaluator.

In addition, if the RSP exceeds $300/day, the RRDS must provide the RSP along with a copy of the RRDS RSP Review form to DOH for review and recommendations. DOH will send the recommendations to the RRDS within three (3) business days.

If there are any discrepancies in the information provided in the RSP, or if it appears that that RSP may not be approved, the RRDS discusses this with the SC. This is documented on the RRDS Revised Service Plan Review form which is sent with the RSP packet to the SC for correction. The SC discusses the issues and/or any alternative options with the participant.

Note: If at any time the RRDS feels the information provided in the ISR from any waiver service provider requires further explanation, they may request that the SC obtain and submit a copy of the Detailed Plan for that service.

The SC returns the corrected/amended RSP packet to the RRDS for re-review within 7 days of receipt.

Upon approval, the RRDS signs the RSP and PPO and returns them to the SC. The SC provides a copy of the RSP and PPO to the participant, all waiver service providers included in the RSP and others as appropriate. The SC may also need to notify other key parties who may not necessarily receive a copy of the RSP.

The RRDS completes and issues the NOD- Authorization to the participant and others listed on the form.
The SC distributes a copy of the NOD form to the approved waiver service providers.
The NOD informs the participant of his/her rights regarding the decision, including Informal Conference and Fair Hearings.

Upon denial of the RSP the RRDS must relay this to the SC and issue the NOD- Denial of Waiver Program to the applicant and others listed on the NOD form.

The SC discusses the concerns with the participant to determine if any alternative options are available for consideration. If appropriate alternatives are not found to meet the participant's health and welfare needs, the SC communicates this to the RRDS.
If the RRDS's determination results in a denial of continued participation in the waiver, the RRDS sends the NOD - Discontinuation of Waiver Program to the participant and others designated on the form. The SC will work with the participant to establish an appropriate discharge plan.

Billing
Policy:
To ensure timely submission of billings, thus ensuring timely turn around in reimbursement.

Procedure:

1. Catholic Charities Disabilities Services Service Coordinators (SCs) are to track monthly face to face visits on the monthly service coordination billing sheet.
2. SCs complete a monthly note within 72 hrs. of visit with Participant, to document the face to face meeting. A copy is given to their supervisor/Associate Director or designee for review.
3. On the first day of the month, the prior month's billings are due to the Associate Directors. Billing sheets can be handed in sooner if all monthly face to face are completed.
4. The Associate Director or designee verifies the monthly face to face against the billing sheet. The Associate Director or designee signs off on the Service Coordination billing sheets and submits them to the Finance Department.
5. The Finance Department reviews the Service Coordination billing sheets to detect any discrepancies. If any discrepancies are noted, the Director or designee will contact the appropriate Service Coordinator and Associate Director or designee for clarification and adjustment if necessary.
6. After the Director's approval, the Finance Department submits the billing to MMIS for payment based on the reported monthly face to face contacts of each Service Coordinator.
7. The Finance Department will retain copies of the billing sheets/monthly notes in the event of a financial audit.

Reimbursement for Service Coordination
Service Coordination must be provided by a DOH approved provider and must be included in the SP to be reimbursed.
There are two (2) types of reimbursement for Service Coordination:

1. Initial Service Coordination is reimbursed on a one-time only basis for each participant after the individual is an approved participant in the waiver. Reimbursement is for the work, time and travel expended in developing the Application Packet, including the Initial Service Plan.
2. Ongoing Service Coordination is reimbursed on a monthly basis. As with all waiver services, Service Coordination must be included in the Service Plan. The Service Coordinator must have, at a

minimum, one face-to-face contact with the participant per month. At least quarterly, one of these visits must occur in the participant's home.

Incident Reporting

This Incident Reporting Policy defines the type of incidents that must be reported and the process all waiver service providers must follow for reporting, investigating, reviewing and tracking the two categories of incidents involving waiver participants:

Serious Reportable Incidents (SRI)

Serious Reportable Incidents (SRI) are defined as any significant event or situation endangering a participant's well-being, and because of the severity or sensitivity of the situation, must be reported to the Regional Resource Development Center (RRDC) and/or NYSDOH.

Classifications of SRI include:

1. **Allegations of Abuse** are defined as the maltreatment or mishandling of a participant which would endanger his/her physical or emotional well-being through the action or inaction of anyone associated with the participant, whether or not the participant is or appears to be injured or harmed.
An allegation of abuse must be classified in the SRI report as one of the following:

a) **Physical Abuse** is defined as physical actions such as hitting, slapping, pinching, kicking, hurling, strangling, shoving, unauthorized or unnecessary use of physical interventions, or other mishandling of a participant. Physical contact that is not necessary for the safety of the person and causes discomfort to the participant or the use of more force than is reasonably necessary is also considered to be physical abuse.
Emergency situations where physical intervention is used to assure the health and welfare of the participant or others must also be reported as a Serious Reportable Incident.

b) **Sexual Abuse** is defined as any sexual contact between a participant and any employee, intern, volunteer, consultant or contractor of the waiver service provider providing services to the participant. Sexual abuse may also occur with any other person living in the community if it is non-consensual or if, according to New York State law, the participant is not competent to consent. Sexual contact is defined as the touching or fondling of the sexual or other body parts of a person for the purpose of gratifying the sexual desire of either party, whether directly or through clothing. Sexual contact also includes causing a person to touch someone else for the purpose of arousing or gratifying personal sexual desires. Forcing or coercing a participant to watch, listen to, or read material of a sexual nature is also considered sexual abuse. A situation in which one participant has a sexual contact with another participant, who is either not capable of consent to or did not agree to participate in the relationship, is considered to be a Serious Reportable Incident.

c) **Psychological Abuse** is defined as the infliction of anguish, emotional pain or distress. Emotional or psychological abuse includes but is not limited to verbal assaults, insults, threats, intimidation, ridicule, humiliation, scorn, contempt, dehumanization or harassment, or are otherwise denigrating or socially stigmatizing. Manipulation, treating an adult like an infant, isolating an individual from family, friends or regular activities, and enforcing social isolation are further examples. The use of language and/or gestures and a tone of voice, such as screaming or shouting at or in the presence of a participant, may in certain circumstances, constitute psychological abuse.

d) **Seclusion** is defined as the placement of the waiver participant alone in a locked room or area from which they cannot leave at will, or from which their normal egress is prevented by someone's direct and continuous physical action.

The act of seclusion should not be confused with a limited quiet time procedure. Quiet time is a procedure in which a waiver participant is accompanied by staff away from an activity for a brief period of time to help the participant recompose themselves. In addition, the participant may request time alone for this same purpose. In removing the participant from ongoing activity, the objective is to offer a changed environment in which the individual may calm down. The use of quiet time is not considered to be an incident unless it is excessive or used as a punishment.

e) **Restraint** is defined as the act of limiting or controlling a person's actions or behavior through the use of any device (physical or chemical) which prevents the free movement of any limb; any device or medication which immobilizes a person; any device which is ordered by a physician for the expressed purpose of controlling behavior in an emergency; or any medication as ordered by a physician which renders the participant unable to satisfactorily participate in services, community inclusion time or other activities.

Note: This does not preclude the use of mechanical supports to provide stability necessary for therapeutic measures such as immobilization of fractures, administration of intravenous fluids or other medically necessary procedures.

f) **Mistreatment** is defined as a deliberate decision to act toward the participant in a manner that goes against that person's individual human rights, the Service Plan, or in a manner that is not generally considered acceptable professional practice. Mistreatment also includes **financial or material exploitation** which is defined as the illegal or improper use of an individual's funds, property, or assets. Examples include, but are not limited to: cashing an individual's checks without authorization or permission; forging an individual's signature; misusing or stealing an individuals' money or possessions; coercing or deceiving an individual into signing any document (e.g., contracts or will); and the improper use of guardianship, conservatorship or power of attorney.

g) **Use of Aversive Conditioning** is defined as the use of unpleasant or uncomfortable procedures when trying to change the behaviors of a participant.

2. Neglect is defined as a condition of deprivation in which the participant receives insufficient, inconsistent, or inappropriate services, treatment or care to meet their needs; failure to provide an appropriate and/or safe environment for receiving services; and/or failure to provide appropriate services, treatment by gross error in judgement, inattention, or ignoring. For example, neglect occurs if a Service Coordinator is aware that an agency listed in a Service Plan cannot provide the requested services, but does not seek an alternate waiver service provider to meet the participant's needs. The Traumatic Brain Injury waiver program recognizes that the failure of staff to attend a scheduled shift may not always put the participant at serious risk; however, to ensure and maintain the health and safety of participants, the need for staff coverage in certain circumstances must be documented in the plan of protective oversight. Failure to meet the conditions of the Plan of Protective Oversight should be reported as a Serious Reportable Incident.

3. Violation of Civil Rights is defined as action or inaction that deprives a participant of the ability to exercise their legal rights, as articulated in State or federal law (e.g., the Americans with Disabilities Act).

4. Missing Person is defined as unexpected or unauthorized absence of a participant taking into consideration their habits, deficits, health problems and capabilities. When the absence of a participant constitutes a recognized danger to the well-being of that individual or others, a formal search must be initiated immediately. This includes contacting informal supports, the Service Coordinator (if not the one discovering the participant's absence), and the police.
For those not considered in immediate danger to self or others, consideration should be given to the missing person's habits, deficits, capabilities, health problems, etc. in making the decision of when to begin a formal search, but this must be initiated no more than 24-hours after discovery that the participant is missing.

5. Death of a waiver participant is defined as any cessation of life due to circumstances unrelated to the natural causes of illness or disease or proper treatment in accordance with accepted medical standards; an apparent homicide or suicide; or unexplained or accidental death. Deaths to due natural cause must be reported to the RRDC within 24 hours; the RRDC will determine if it will be categorized as an SRI. The follow-up report of the investigation submitted to the RRDC must include information concerning the death, and if obtainable medical records, death certificate, police reports, autopsy reports, EMS records, emergency room records and any other information deemed relevant.

Note: All deaths should be reported to the RRDC, and from there the RRDC will decide if the death is an SRI or Recordable Incident.

6. Unplanned hospitalization is defined as any injury or illness which results in a hospital admission of a participant for treatment or observation for greater than 24 hours due to the injury/illness.

7. Possible Criminal Action is defined as any action by a participant that is or appears to be a crime under New York State or Federal law. Improper action taken by staff is to be included in Violation of a Participant's Civil Rights or other related categories.

8. Medication Error/Refusal is defined as any situation in which a participant experiences marked adverse effects or their health or welfare is in jeopardy due to incorrect dosage, administration or refusal to take prescribed medication.

Consideration must always be given to a participant's right to make choices for themselves and their right to accept risks. If an action by either a waiver service provider or by a participant may have jeopardized a participant's health or welfare even though it did not result in an adverse reaction, the waiver service provider still must investigate the situation and record the action as a Recordable Incident (refer to the Recordable Incident process found in this section). The investigating agency will maintain documentation of the incident investigation and its outcome.

The Recordable Incident will rise to the level of a Serious Reportable Incident if the investigation uncovers that the participant did, in fact, experience an adverse reaction (refer to the Serious Reportable Incident protocol in this section).

Recordable Incidents
The waiver service provider will also be responsible for the management of Recordable Incident reports (those that do not rise to the level of an SRI to notify RRDC, but that the agency would like to document internally) and related investigation processes.

Recordable Incident is defined as an event that does not pose an immediate threat to the participant and does not meet the level of severity of a Serious Reportable Incident but may compromise the participant's safety and well-being if not noted, reported and addressed. These incidents warrant an internal investigation by the provider agency's quality assurance unit for trends and outcomes.

Recordable incidents are not reported to New York State Department of Health but may be audited as needed. Recordable Incidents are reported annually to the Regional Resource Development Center and are subject to review upon site visit by the Regional Resource Development Center and/or New York State Department of Health. The New York State Department of Health reserves the right to review these incidents at any time.

Classifications of Recordable Incidents include:

1. **Injury** is defined as any suspected or confirmed harm to a participant caused by an act or person, accidental in nature or one that the cause cannot be identified, which results in a participant required medical or dental treatment and such treatment is more than first aid. The RRDC will determine if it will be categorized as a Recordable Incident or re-classified as a Serious Reportable Incident.
2. **Natural Death** of a waiver participant is due to natural causes when in a treatment facility or hospice environment. Deaths due to natural causes **must be** reported to the RRDC within 24 hours and the RRDC will determine if it will be categorized as a Recordable Incident or SRI.

3. **Sensitive Situation** is defined as any situation related to a participant that needs to be monitored for a potential adverse outcome. This includes events that attract media attention or inappropriate activity which could threaten the participant's ability to remain in the community. The RRDC will determine if it will be categorized as a Recordable Incident or re-classified as a Serious Reportable Incident.

At Catholic Charities Disabilities Services, the Quality Assurance (QA) Department is the administrator of the incident reporting process, both Serious Reportable Incidents and Recordable Incidents, ensuring the process is initiated, investigated and completed in a timely manner, outcomes are appropriate and waiver service provider follow-up is conducted. This section also defines the responsibilities of the Regional Resource Development Center (RRDC), Service Coordinator (SC) and other waiver service providers, and DOH Waiver Management staff (WMS) in the investigation process.

Just as a variety of individuals associated with a waiver service provider may be involved in an alleged SRI they may also be a witness of such actions. The requirements for reporting this event also takes into account that the actual witness is obligated to inform his/her supervisor. In such cases the supervisor may be the one to report the alleged Serious Reportable Incident to the QA Department.

In situations where only a family member or other informal support has witnessed the SRI or when there were no witnesses to the incident, the waiver service provider employee, who was made aware of the incident or his/her supervisor is responsible for filling out the reporting form and is considered to be the discoverer of the incident.

Regardless of who reports the incident, the RRDC will assign the responsibility for the investigation to the waiver service provider agency whose employee was allegedly involved. If the incident does not involve a waiver service provider's employee, the RRDC has the discretion to assign the responsibility of the investigation to any of the participant's waiver service providers or to undertake the investigation themselves.

Procedure:
Reportable Incidents
Reporting Responsibilities

When a waiver service provider discovers that an 'Event' has occurred, the agency has twenty-four (24) business hours to initiate an investigation to determine whether the 'Event' is a Serious Reportable Incident.

If the incident involves any type of abuse listed or the death of a participant, the SC must notify RRDC immediately via phone and/or providing a copy of the "**Initial Report**" form.

Upon request of RRDC, SC will provide copies of any other forms related to the incident.
When appropriate, any waiver service provider or waiver entity may contact Adult Protective Services (APS) related to an alleged incident involving a waiver participant at any time during the Serious Incident Reporting process. In addition, a waiver service provider, SC, RRDC or QA Department must assure the participant is reminded of their right to notify the police as appropriate. The QA Department will assure that any known contact made by the provider with APS or with the police has been appropriately documented on the "Initial Report", "24-Hour Provider Report", "Provider Follow-Up Report", or subsequent "Provider Follow-Up Reports".

1. Within twenty-four (24) hours of discovery, the SC completes the reporting waiver service provider must complete and send the "**24-Hour Provider Report**" via encrypted email to RRDC. The SC then provides a copy of the initial and 24 hour report to the QA Department for confirmation and tracking.

   Note: *If the SC is alleged to be involved in the incident, and it is reported by an outside agency, the outside agency will initiate the initial and 24 hour report and RRDC is responsible to notify the SC Supervisor and QA Department.*

   Note: *If the SC is the alleged to be involved in the incident and the SC Supervisor is contacted first, the SC Supervisor will initiate the initial and 24-hour report and send it to RRDC. RRDC will then assign an investigator.*

2. Upon receipt of the 24-hour report, the SC must contact the participant and/or legal guardian and informs them that an investigation is under way. In addition, the SC must notify any other waiver or non-waiver provider currently involved in the Service Plan (SP) when there is visible evidence of injury to the waiver participant or when the incident or response to the incident may impact services or activities.

   Consideration of the individual's privacy should be balanced against the need to notify only service providers who need to know for the purpose of service delivery. Contact with the waiver participant and/or legal guardian and/or other waiver service providers must be documented using the Service

Coordinator 24-Hour Notification Report. The SC sends this report to the QA department and then it's forwarded to the RRDC .

Note: *If the SC is alleged to be involved in the incident, the Service Coordination Supervisor is responsible for contacting the participant and following Step #2 above.*

3. Within twenty-four (24) hours of receiving the 24-Hour Provider Report, the Regional Resource Development Center will review the form and then complete the Regional Resource Development Center Initial Response form. Upon entry into the database, an incident number is automatically assigned to the incident. This number must be included in all future reports and correspondence relating to the incident.
    a. Classification and Category Verification The Regional Resource Development Center will document on the Regional Resource Development Center Initial Response acceptance of the original classification or, if indicated, the re-classification of the incident. If the Regional Resource Development Center determines that the incident does not meet the definition of a Serious Reportable Incident and re-categorizes the incident as a Recordable Incident, this must be noted on the Regional Resource Development Center Initial Response. In this instance, the case is considered CLOSED. The Regional Resource Development Center also completes the Regional Resource Development Center Status Report form.
    b. Assigning the Investigation The Regional Resource Development Center will determine which waiver service provider will be responsible for conducting the investigation and will contact the waiver service provider to discuss the waiver service provider's plan for investigating the incident. The Regional Resource Development Center will forward the Regional Resource Development Center Initial Response and the 24-Hour Provider Report to the investigating waiver service provider. The Regional Resource Development Center will also send a copy of the Regional Resource Development Center Initial Response to the discovering waiver service provider (if different from the investigating waiver service provider) and the Service Coordinator. The Regional Resource Development Center will provide technical support to the waiver service provider and may request assistance from New York State Department of Health waiver staff in the process, if necessary. The Regional Resource Development Center will document contact on the Regional Resource Development Center Initial Response and provide the dates of the expected seven (7) calendar day and thirty (30) calendar day Provider Follow-Up Reports. If there is concern regarding a potential conflict of interest or appearance of a conflict, the Regional Resource Development Center will assign another waiver provider who provides services to the individual to conduct the investigation. The Regional Resource Development Specialist and/or Nurse Evaluator will conduct the investigation if the scope of the incident goes beyond one (1) waiver service provider, there is an appearance of conflict of interest among the providers, the provider has demonstrated non-compliance with program manual standards or improper procedures, or the New York State Department of Health requests the RRDC completes the investigation.

NOTE: The Regional Resource Development Center must notify the New York State Department of Health of any extraordinary events within twenty-four (24) hours of receipt of the 24-Hour Provider Report.

4. The investigating waiver service provider must designate at least one (1) individual to be responsible for conducting a thorough and objective investigation or may choose to contract with another

agency to conduct the investigation. The investigator is required to have documented experience and/or training in conducting investigations. Those conducting the investigation must not be directly involved in the incident; an individual whose testimony is incorporated in the investigation; or individuals who are the supervisor, supervisee, spouse, significant other or immediate family member of anyone involved in the investigation. At the same time, the investigating waiver service provider must notify its Serious Incident Review Committee (refer to the section below – Provider's Serious Incident Review Committee) that an investigation has been assigned.

5. Within seven (7) calendar days of receiving the Regional Resource Development Center Initial Response and the 24-Hour Provider Report, the investigating waiver service provider must complete and submit the Provider Follow-Up Report to the Regional Resource Development Center, including all formal investigating agency reports, interview statements, and any contact made with the Serious Incident Review Committee.

6. Within seven (7) calendar days of receiving the Provider Follow-Up Report (7-day), the Regional Resource Development Center will review the form and provide a written response to the investigating waiver service provider as to whether the information received is sufficient to close the incident or whether it must remain open for further investigation, using the Regional Resource Development Specialist/Nurse Evaluator for consultation as needed. The Regional Resource Development Center will complete the Regional Resource Development Center Status Report form indicating whether the case:
   a) Is re-classified (with explanation);
   b) Remains open (and the reason why); and/or
   c) Is closed, including documentation of whether the incident was substantiated or not, and why.

   If left open for further investigation, the investigating waiver service provider must continue the investigation process and prepare information for submission of the completed Provider Follow-Up Report (30-day). The Regional Resource Development Center will send a copy of the Regional Resource Development Center Status Report to the Service Coordinator and the investigating waiver service provider.

   a. If the investigation remains open, the investigating waiver service provider must submit a Provider Follow-Up Report to the Regional Resource Development Center within thirty (30) calendar days (as designated on the Regional Resource Development Center Initial Response) for review, with copies of all reports, statements, and supporting documentation attached.

   b. Within seven (7) calendar days of receipt of the Provider Follow-Up Report (30-day), The Regional Resource Development Center will complete the Regional Resource Development Center Status Report indicating whether the case:

      a) Is re-classified (with explanation);
      b) Remains open (and the reason why); and/or
      c) Is closed, including documentation of whether the incident was substantiated or not, and why.

   c. If further investigation is deemed appropriate by the Regional Resource Development Center, a Provider Follow-Up Report must be submitted by the investigating waiver service

provider monthly (every thirty (30) calendar days). The due date is based on the designated thirty (30) calendar day due date indicated in the Regional Resource Development Center Initial Response. In each case, the Regional Resource Development Center staff has seven (7) calendar days to review the monthly report and provide a completed Regional Resource Development Center Status Report to the investigating waiver service provider indicating whether the incident remains open or is closed and why, including documentation of whether the incident was substantiated or not. A copy of each Regional Resource Development Center Status Report is forwarded to the Service Coordinator by the Regional Resource Development Center. For the Regional Resource Development Center to consider an investigation to be closed:

a. The final investigation report must be submitted to the Regional Resource Development Center, along with the Provider Follow-Up Report; and
b. The provider's Serious Incident Review Committee must have met, reviewed the investigation, and recommended that the incident be closed. The Serious Incident Review Committee must also provide the Regional Resource Development Center with suggestions post review. The Regional Resource Development Center reviews the final investigation report and the supporting document(s) to determine if the investigation process has been sufficient. If the Regional Resource Development Center has a question about the substance of the investigation it will refer the report to the New York State Department of Health for review and guidance. If the investigation is to remain open, the reasons for that decision must be identified by the Regional Resource Development Center in the Regional Resource Development Center Status Report along with directions for further investigative action. The Regional Resource Development Center returns the investigation report to the provider, requesting additional clarification and/or information. No incident investigation may remain open for more than ninety (90) days from the date of the 24-Hour Provider Report without the approval of the Serious Incident Review Committee, the Regional Resource Development Center and/or the New York State Department of Health. This approval will occur in only in the most atypical circumstances, for example, criminal investigation, civil litigation.

Serious Reportable Incident investigations pertaining to unplanned hospitalizations must be closed within the timeframe of ninety (90) days from the date of the 24-Hour Provider Report, not after discharge from the hospital. The investigation is not closed until the Regional Resource Development Center determines it is closed. When the case is deemed closed, the Regional Resource Development Center must complete the Regional Resource Development Center Status Report, sending a copy to the Service Coordinator and the investigating waiver service provider. Once the investigating provider receives the final Regional Resource Development Center Status Report, it must send written notice to the participant/legal guardian within seven (7) calendar days that the investigation has completed, indicating the final outcome without disclosing the details of the investigation. The provider must forward a copy of the letter to the Regional Resource Development Center and Service Coordinator. If the case is re-classified, the investigation must continue under the same protocol as if open, until the Regional Resource Development Center can determine that the investigation has been completed and the case can be closed, including documentation supporting the determination.

7. Once the investigation is closed, the Regional Resource Development Center must also notify the participant/legal guardian within seven (7) calendar days via a close-out letter indicating the

investigation is completed and forward a copy to the Service Coordinator. Although details of the investigation are not disclosed, the final outcome is provided to the participant/legal guardian. A summary of the investigation findings will be included in the letter

8. The QA Department will maintain a tracking system to ensure that appropriate follow up to SRIs are being completed within the necessary timelines. Please see Department Protocol "TBI Incident Process and the Role of Quality Assurance."

Recordable Incidents

Incidents must include an explanation or identification of the:

1. Process for identifying patterns of incidents that involve a specific participant or staff within the agency that threaten the health and welfare of participants in general.
2. Staff person responsible for the oversight and assessment of Recordable Incidents within the organization;
3. System for tracking the reporting, investigation and the outcome of all Recordable Incidents which includes:
    - Name and Client Identification Number of the participant;
    - Identity of any individuals associated with the participant at the time of the incident;
    - Date(s) and time of the incident; and
    - Description of Incident; and
4. Action(s) taken by the waiver service provider, including recommendations for changes in the circumstances associated with the incident criteria used to determine when a Recordable Incident should be upgraded to a Serious Reportable Incident to be reported to the Regional Resource Development Center.

All Recordable Incident Reports must be sent to the RRDC for review and to ensure that the incident does not require reporting as an SRI.

The Regional Resource Development Center may request Recordable Incidents at any time if deemed necessary, for instance, when investigating a complaint.

Provider's Serious Incident Review Committee

1. Organization and Membership of the Serious Incident Review Committee:
    - The Committee may be organized on an agency-wide, multi-program or program-specific basis.
    - The Committee must contain at least five individuals. A minimum of five members must be present any time the committee convenes. Participation of a cross section of staff, including professional staff, direct care staff and at least one member of the administrative staff is strongly recommended.
    - The Executive Director of the agency shall not serve as a member of the Committee but may be consulted by the Committee in its deliberations.
    - The Program Administrator for TBI Waiver services may be designated as a member **only** if the Committee is an agency-wide or multi-program committee.
    - The individual assigned to conduct investigations for the agency can be part of the Committee, but may not serve on the Committee at the same time they are involved in an active investigation for the agency.
    - The Committee must meet at least quarterly, and always within thirty (30) days of a report of a SRI involving a TBI waiver participant.

2. Responsibilities of the Serious Incident Review Committee

This Committee is responsible for reviewing the investigation of every SRI. The SIRC will evaluate whether the investigation has been thorough and objective. It will determine if the conclusions and recommendations of the investigator are in line with generally accepted professional standards and are in compliance with the guidelines of the TBI waiver.

In addition, the Committee will:

a) Ensure that the providers' Incident Reporting Policies and Procedures comply with DOH TBI Incident Reporting Policy as detailed in this Program Manual.
b) Review all SRI and Recordable Incidents to assure that incidents are appropriately reported, investigated and documented.
c) Ascertain that necessary and appropriate corrective, preventive, and/or disciplinary action has been taken in accordance with the Committee's recommendations. If other actions are taken, the Committee must document the original recommendations and explain why these recommendations were revised.
d) Develop recommendations, if warranted for changes in provider policy and procedure to prevent or minimize the occurrence of similar situations. These recommendations must be presented to the appropriate administrative staff.
e) Identify trends in SRI (by type, client, site, employee, involvement, time, date, circumstance, etc.), and recommend appropriate corrective and preventive policies and procedures to the agency administration.
f) The QA Department reports quarterly and annually regarding SRI, Recordable Incidents and all corrective, preventive and/or disciplinary actions taken pertaining to identified trends.

   The annual report must include the name and position of each of the members of the committee and documentation of any changes in the membership during the reporting period. This report will be submitted to the RRDC in each agency's region where the provider is authorized to provide waiver services by January 31 of each year for the prior year; for review, regional trend analysis and recommendations for interventions. RRDC forwards the report with analysis to DOH WMS for further review. DOH may request reports at any time.

3. Documentation of Serious Incident Review Committee Activity

- The chairperson shall ensure that minutes are kept for all meetings and maintained in one location.
- Minutes are to be maintained in a manner that ensures confidentiality.
- Minutes addressing the review of SRI shall state the identification number of the incident (provided by QAS and the participant's CIN, a brief summary of the situation that caused the report to be generated (including date and type of incident), Committee findings and recommendations, and actions taken on the part of the agency/program as a result of such recommendations.
- DOH may request to review minutes at any time.

All information regarding SRI reports, including but not limited to the information collected to complete the investigation and the investigation report and minutes of the standing SIRC, must be maintained separately from the participant's records.

Agency Policies

Canceling Services and/or Providing Back-Up Staffing

Policy:
To provide a continuum of care for our individuals by assuring a minimum of disruptions to their services under all circumstances.

1. In the event of a minor illness or conflict in schedule, the Service Coordinator shall arrange for substitute coverage when appropriate or reschedule the appointment or meeting.
2. In the event of a long-term illness or absence of a Service Coordinator, the Director and Associate Directors or designee will designate other SC's to the case and/or cover the caseload themselves. The participant also has the right to change SC Provider Agencies.

Changing Service Providers at the Participants' Request
Policy:
Catholic Charities Disabilities Services will ensure that the participant has the choice to change TBI Waiver Providers. When a TBI Waiver Participant expresses a desire to change a provider, the following procedure will be implemented.

Procedure:

1. The Service Coordinator will investigate potential agencies and providers on behalf of the individual and report back to the participant/family, so that they can make an informed choice.
2. The Service Coordinator will assist the participant with tours and interviews of potential programs, services and support.
3. When a change in service provider is decided upon, the Service Coordinator will complete the necessary paperwork for enrollment and submit it as soon as possible to the appropriate parties for approval.
4. If there is a requested change in providers for Service Coordination, the issue at hand will be discussed with the participant/family by the Associate Director or Director. A reasonable attempt to rectify the situation will be made (i.e.: change of internal Service Coordinator). If the problem cannot be rectified, RRDS personnel will be notified and involved if necessary, and a change in Service Coordination agency will occur.

Process for Changing a Provider
The participant's ability to change a waiver service provider is an essential component of assuring participant choice. It also allows a waiver service provider the opportunity to recognize that it can no longer meet the participant's service needs.

A. Participant Request
If the participant chooses to change their waiver service provider, the SC must comply utilizing the following procedure:

1. The participant or his/her current SC informs the current waiver service provider of the participant's intention to change providers;
2. The SC will provide the participant with a list of approved and available waiver service providers for the participant to interview and choose from;
3. Upon selection of a new waiver service provider, the participant will inform the SC of his/her preference. The Service Coordinator will complete the Change of Provider Request form with the participant and send the completed and signed form to the selected waiver service provider agency;

4. The requested waiver service provider must review the form and complete the statement of Requested Provider indicating the approval of the participant's request or the denial of the participant's request with reason. The form must then be returned to the Service Coordinator;
5. When the requested waiver service provider declines the participant's request for services, the SC must inform the participant and ask him/her to select another waiver service provider agency from the list. The selection process proceeds. The Service Coordinator maintains all completed Change of Provider forms in the participant's record;
6. When the requested provider accepts the participant's request, the SC submits the Change of Provider Request form to the RRDS for review and determination. The RRDS's decision is documented on the Change of Provider Request form and sent back to the SC;
7. If the RRDS approves, the SC will establish a date and time for the Transition Meeting and documents this on the Change of Provider Request form.
   Note: The Transition Meeting provides an opportunity for current provider(s) to meet with newly selected providers to exchange information ensuring the success of the new provider(s) with the least amount of disruption to the participant. The SC documents this information on the Change of Provider Request form;
8. The RRDS reviews the request and upon approval, sets an effective date for the change. The RRDS will send the approved Change of Provider form to the participant, SC, and all current and new waiver service providers;
9. If the RRDS cannot approve the request for change in waiver service provider, the RRDS will indicate the reason why (e.g. Vendor Hold status or the waiver service agency is no longer an approved provider of TBI services) on the Change of Provider Request form and immediately notify the SC, sending the form back to the SC to be maintained in the participant's record. No NOD is issued by the RRDS in this case. However, for all other instances where the RRDS cannot approve a request for change in waiver service provider, the RRDS will complete and send the NOD- Denial of Waiver Provider/Waiver Service form to the participant and others designated on the form;
10. The SC must work with the participant to select another waiver service provider restarting the Change of Provider process;
11. When the request for Change in Provider is approved by the waiver service provider agency and the RRDS, the SC must facilitate the Transition Meeting where participant information is reviewed and transferred to the new provider, assuring a smooth transition occurs;
12. Once this process is completed, the SC must update the Waiver Contact List and provide a copy to the participant and other current waiver service providers as appropriate;
13. If the participant chooses to change the Service Coordination agency, the RRDS must work directly with the participant through the above process; and
14. The participant, SC or any provider should contact the RRDS if this procedure is not followed.

B. Provider Request

When a waiver service provider is unable to or wishes to no longer provide services to a participant, the following procedures must be followed:

1. The waiver service provider agency must inform the participant of its intent to terminate service provision. This must be done at a minimum of ten (30) calendar days prior to stopping the provision of service(s);
2. Notification must be sent via certified letter or directly delivered to the participant. A copy of the letter must also be sent to the Service Coordinator and the RRDS;
3. Reasons for the termination must be included in the letter;

4. The SC must provide the participant with a list of available waiver service providers from which to interview and select;
5. If it is the SC agency requesting termination, then the RRDS is responsible for providing the participant with a list of available SCs/agencies from which to select;
6. Upon selection of the new waiver service provider, the participant must inform the SC (or RRDS as appropriate) who will assist the participant through the completion of the Change of Provider Request form;
7. The current provider agency must work closely with the newly requested provider agency and the SC (or RRDS, as appropriate) to assure a smooth transition occurs and that all appropriate documentation is provided to the new agency; and
8. The SC must amend the Service Plan to reflect the change in waiver service provider.
   Note: The above procedures do not replace any professional requirements which a provider must follow in accordance with professional credentialing or licensing rules.

C. As a Result of Staff Leaving

When a staff member of a waiver service provider agency will no longer be providing services to a participant, the following procedures must be followed:

1. The staff member or agency supervisor must notify the participant of the employee's intent to leave his/her current agency and directs the participant to discuss the impact of their leaving with his/her SC. The participant can remain with the agency or choose to change providers. If it is the SC who is leaving the agency, the participant will be directed to the RRDS to select a new SC.
2. The staff member or the agency supervisor notifies the SC of the staff member leaving the agency.
3. The SC meets with the participant to determine if a new provider agency is desired. If the participant desires a new waiver service provider agency, the SC will assist him/her through the Change of Provider process (refer to Changing Waiver Provider section above).
4. If the participant chooses to remain with the current waiver provider agency, the SC must work with the participant and agency supervisor to assure no lapse in staff coverage occurs.
5. The SC will amend the current Service Plan to reflect the change, if needed.
6. When it is the SC leaving the agency, the RRDS will talk with the participant about his/her continued interest in remaining with this Service Coordination agency. If the participant desires to change Service Coordination agencies, the RRDS will assist him/her through the change of Service Coordination process.
7. If the participant chooses to remain with the current Service Coordination agency, the agency will work with the participant and agency supervisor to assure no lapse in staff coverage occurs. A Change of Service Coordinator form will be completed to indicate who the new SC from the current agency will be.

D. Establishing the Date of Termination

As a final step in the process of changing waiver service providers, the RRDS will establish the date of termination to assure no lapse in service provision occurs to the participant. In doing so, the following must occur:

- Service Coordination must change on the first of the month; and
- Other waiver services may be changed within ten (30) business days from the RRDS receipt of the signed Change of Provider form. The RRDS may make the change of providers effective upon receipt of the Change of Provider Request form if it is determined that the health and welfare of the participant is at risk. This may be accomplished verbally or in writing.

During the transition period, the SC will arrange for a Transition Meeting between the current and new providers and the participant to exchange information. In the event the SC is the staff member leaving, the RRDS will arrange for a Transition Meeting between current and new provider to exchange information. The current provider is responsible for providing the new provider with copies of all evaluations, Individual Service Reports, and an update of what has been accomplished since the last Service Plan. This process must comply with all laws, such as the Health Insurance Portability and Accountability Act (HIPAA), regarding confidentiality and the release of medical and TBI waiver services material.

Accessing Services and Supports on behalf of the Participant
(Offering choice of Service Coordinators)
Policy:
All participants of the TBI Waiver will be offered choice of services and supports.

Procedure:

1. The Intake Service Coordinator from Catholic Charities Disabilities Services and/or the assigned Service Coordinator will complete the intake with the applicant.
2. As services are requested, the Service Coordinator will investigate potential agencies and providers on behalf of the individual and report back to the participant/family, so that they can make an informed choice. The Service Coordinator will assure case notes reflect activities taken that offer choice of providers to the individual.
3. The Service Coordinator will assist the participant for tours, referral packets, interviews, etc. of potential programs, services and supports.
4. When a service is decided upon, the Service Coordinator will complete the necessary paperwork to enroll the participant in the desired service and submit it as soon as possible to the appropriate parties for approval.
5. Upon written documentation of approval for a service, the Service Coordinator will notify the new provider when they are authorized to begin services with the participant.

Filing a Complaint/Grievance
Policy:
Individuals, their advocates or guardians receiving servicing through Catholic Charities Disabilities Services will have the ability to register a complaint or grievance that they may have with Catholic Charities Disabilities Services. The complaint/grievance will be investigated in a timely manner. Catholic Charities Disabilities Services Service Coordinators and other qualified personnel will inform individuals of the Complaint/Grievance Policy at the time of intake as well as annually for TBI participants.

Procedure:

1. Upon intake and annually thereafter, each individual, advocate or guardian will be provided with the grievance procedure form which states who to file a complaint/grievance with. They will also have the policy explained to them.
2. An individual/advocate or guardian verbally or in writing states their complaint to the primary Service Coordinator. If the person is uncomfortable discussing the complaint with the primary Service Coordinator, they may file their complaint with the Director.

Waiver Service Provider's Internal Complaint Procedure
Each waiver service provider must develop and implement a process for responding to complaints made by participants or other(s) on his/her behalf (e.g. guardian, family members or advocates). This process must be clearly written, easy to navigate and provided to the participant.

The complaint policy must include:

1. A description of how to register a verbal or written complaint, that registering a complaint in no way jeopardizes his/her right to receive services, who is responsible to receive and respond to the complaint, and a time frame for making initial contact with the participant (within seventy-two (72) hours) upon receipt of complaint;
2. A time frame for completing a complaint investigation and providing a written response to the complainant (maximum of thirty (30) calendar days from receipt of initial complaint);
3. An appeals process, including timeframes, if the person who registered the complaint is not satisfied with the response (**to be completed in no more than fifteen (15) calendar days from notice from the complaint**);
4. Additional appeals process, in which the complaint is forwarded to the provider agency's governing authority for review and recommendations (**to be completed in no more than fifteen (15) calendar days from receipt of the information**); and
5. Notification to the participant of his/her right to contact the RRDS if not satisfied with the outcome of the agency's response.

If the RRDC is not able to resolve the difficulties, the RRDS forwards the matter to the DOH WMS for review and final resolution.

Note: At any time, the participant has the right to notify his/her SC regarding registering of a complaint with a provider agency. The participant may request that the SC act as advocate for the participant assisting him/her through the complaint process with the provider agency. The SC and/or participant may contact the RRDC for assistance when the appeals process does not lead to a satisfactory resolution.

There may be times when a complaint must be converted to a Serious Reportable or Recordable Incident report. A provider must inform the individual filing the complaint that this has occurred, the reason for converting the complaint, and documents the incident review process.

Information regarding complaints must be made available to DOH WMS upon request and to DOH during survey of the agency.

Quality Assurance and Assessing Participant Satisfaction
Policy:
Participant satisfaction and quality services are of the utmost importance. At least annually, consumer satisfaction will be formally assessed, with monthly check-in via SC and at least semi-annually with the team of providers.

Procedure:

1. Each year a Satisfaction Survey will be mailed with a self-addressed, stamped envelope to all individuals receiving Service Coordination through Catholic Charities Disabilities Services. They will be given the option to complete anonymously or write in their name.

2. During monthly contacts, the Service Coordinator will directly inquire as to the satisfaction with services. The Service Coordinator will document the response in the case notes.
3. When the surveys are returned, they will be reviewed by the Directors team and Quality Assurance, and any problem areas will be dealt with swiftly either verbally or in writing by the Director. Satisfaction Surveys will be retained by the Quality Assurance Department.
4. A summary of the Satisfaction Surveys will be presented to the Board of Directors by the Executive Director that will identify any areas of concern and corrective actions to be taken. Positive results are also shared.
5. Quality Assurance will conduct an ongoing record review of the Service Coordinators' binders using the appropriate case record review form TBI for Service Coordination. The Service Coordinator will have 2 weeks to address any deficiencies noted. Review of the corrections will be completed at the individual supervisory meeting with the Director, Associate Director or designee once every three weeks.
6. Every three weeks during regularly scheduled supervision meetings, the Service Coordinator will have two random record reviews. On an annual basis, each Service Coordinator will have full caseload chart audit.

Service Plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Activities:

a) The RRDS meets every potential waiver participant prior to the development of the ISP. This provides the RRDS with information regarding the potential waiver participant's unique strengths and needs. This information is used when the RRDS reviews the Initial SP. The information acquired by the RRDS during this interview is documented on a standardized Intake Form which is shared with the selected SC and used to develop the ISP.

b) The SC works with the waiver participant to establish the ISP, RSP and any Addenda. The SP includes the range of services needed by the waiver participant including waiver and non-waiver services. It combines all services needed to address the waiver participant's health and welfare, personal goals, preferences and cultural traditions.

c) The waiver participant's signature on the SP signifies that he/she has read it or it has been read to him/her and they understand its contents and purpose.

d) A Plan of Protective Oversight (PPO) is completed with the waiver participant by the SC during the development of the ISP and at each RSP.

e) The PPO is reviewed with the participant by the SC during the development of an Addendum. Any changes in the PPO will result in the completion of a new PPO for submission to the RRDS with the Addendum. If no changes are indicated, the PPO is signed indicating the contents remain the same and attached to the Addendum.

f) All SPs are forwarded to the RRDC for final review and approval. The RRDS conducts a comprehensive review of 100% of all SPs assuring the waiver participant's goals and preferences are recognized and the plan meets his/her health and welfare needs.

g) If the RRDS finds the SP does not reflect the waiver participant's needs and goals, support health and welfare or follow the program's policies, immediate corrective action must be requested from the SC and completed before the SP can be resubmitted to the RRDS for re-review.

h) If a SP exceeds $300/day, the RRDS sends it to DOH for review before approval.

i) Waiver Service providers assess waiver participant satisfaction by conducting annual Participant Satisfaction Surveys and by investigating all complaints/grievances received. These surveys and complaints/grievances investigations will be viewed by DOH during the survey process.

j) Any calls received regarding the SP by DOH WMS, directly or through the TBI Complaint Line, or issues raised to DOH WMS during the annual Regional Forums regarding waiver participant SPs, will be directed by DOH WMS to the RRDS. If the issues are of significant concerns and constitutes ad SRI, it must be referred to the QAM for follow up. As a result of the investigation, changes may be required to the SP.
k) The QA dept. assures Participant Satisfaction Surveys are conducted annually, analyzing data for waiver provider performance, SP implementation and regional trends. The outcomes of these surveys must be provided to RRDC. When individual issues arise as a result of these interviews, the RRDC informs the Director to ensure action is taken to remedy the situation.
l) During annual random retrospective record review conducted by DOH WMS, all approved SPs will be reviewed at a rate of at least five-percent (5%) in Year One of the waiver, two-percent (2%) in Year Two, and one-percent (1%) in Year Three.
m) The data gathered regarding this assurance must be included in the RRDS and/or QAM Quarterly Reports for review by DOH Waiver Management staff. That staff, in consultation with the QAM and RRDS will evaluate the need to change and/or improve policies/procedures.

The state monitors Service Plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in Service Plan development.

Activities:

a) The RRDS is responsible to review 100% of all SPs to assure the plans are developed in accordance with waiver participant needs and goals, meet health and welfare, and reflect the policies and procedures of the waiver program. Any discrepancies in the SP must be referred back to the SC by the RRDS for further assessment and/or modification before re-review by the RRDS for approval.
b) Each SP submitted to the RRDS for review and approval must be signed by the waiver participant to assure the waiver participant has read it or it has been read to him/her and that he/she understands its contents and purpose.
c) The RRDS assures all SPs over $300/day are reviewed by DOH prior to final approval.
d) The RRDS examines all SRIs in relationship to the SP to understand if a change in the type or amount of service is needed and works with the SC to assure any immediate needed changes in the SP are made at the waiver provider level.
e) The SC is responsible to assure that a safe and effective SP is established with the waiver participant's involvement and support. Plans are formulated initially and revised at least every six months or with more frequent Addenda, as needed. The SC must have a tracking system in place to guarantee the timeliness of SPs.
f) The SC is responsible for facilitating Team Meetings with the waiver participant and all key parties to review the SP for revisions, to ensure the waiver participant is involved and the waiver participant's preferences are reflected in the SP.
g) The SC submits the SP to the RRDC for review to assure the SP is appropriate and to avoid any lapse in service coverage.
h) DOH WMS monitor TBI Complaint Line calls, data from the Regional Forums, complaints and annual Participant Satisfaction Surveys for trends or issues related to the SP. They will initiate an investigation to obtain further information regarding any identified issues.
i) DOH WMS may place restrictions on waiver providers for late submission of RSPs and/or Individual Service Reports (ISR). Restrictions may include the discontinuance of the waiver provider agreement or a vendor hold, which prevents the waiver provider from accepting new waiver participants until the RSP and/or ISR is submitted and approved by the RRDS. In addition,

the waiver provider may have to submit a plan of action if the submission of late SPs is an ongoing problem.

j) Where inadequacies in the SP development process are identified, DOH WMS request a review by the RRDS and/or a DOH survey of any waiver provider.
k) DOH WMS conduct annual random retrospective reviews of five-percent (5%) of all SPs in Year One of the waiver, two-percent (2%) in Year Two, and one-percent (1%) in Year Three. DOH WMS reserve the right to review SPs at any time.
l) The data gathered regarding this assurance must be included in the RRDS Quarterly Reports for review by DOH WMS. That staff, in consultation with the RRDS evaluates the need to change and/or improve policies/procedures.

Service Plans are updated/revised annually or when warranted by changes in the waiver participant's needs.

Activities:

a) The SC must assure Team Meetings are held at the 30 day mark (from the NOD start date) mid service review months (7 months from NOD start date) with the waiver participant, key parties and anyone the waiver participant requests for the purpose of reviewing the SP for needed revisions and development of an RSP.
b) An Addendum is used when there is a need for minor adjustments in the SP. The Addendum is a short form the RRDS can review and approve quickly. An RSP is used when there are major changes in the types and amounts of waiver services needed to assure health and welfare.
c) All RSPs and Addendums must be reviewed and approved by the RRDS assuring waiver participant needs, goals, and health and welfare are met.
d) A waiver participant may request a review of his/her SP at any time and the SC must comply with this request. If needed, a Team Meeting will be held with all appropriate persons in attendance.
e) In the event the outcome of an investigation of an SRI, Recordable Incident or complaint leads to an Addenda or revisions in the SP, the RRDS assures changes are implemented in a timely manner by waiver providers.
f) The SC and RRDS track the submission and review of all SPs according to policy and procedure.
g) In the event SPs are delinquent, RRDS notifies DOH WMS.
h) The data gathered regarding this assurance must be included in the RRDS Quarterly Reports for review by DOH Waiver Management staff. That staff in consultation with the RRDS evaluates the need to change and/or improve policies/procedures.

Services are delivered in accordance with the Service Plan, including in the type, scope, amount, duration, and frequency specified in the Service Plan.

Activities:

a) The SC maintains regular contact with the waiver participant to discuss the delivery of services as approved in his/her SP.
b) Discrepancies between SPs and actual service utilization may be discovered through a range of methods including a random retrospective review by DOH WMS of SPs against claims data acquired through eMedNY, OMIG audits of waiver providers, DOH surveys and audits of waiver providers, Line calls, waiver provider Participant Satisfaction Surveys, and Regional Forums regarding waiver participant experiences with provision of services. If problems are discovered, further investigation will be pursued. If it is found services are not being delivered in accordance with the SP, DOH WMS will take appropriate action which may include a Vendor Hold or termination of the Provider Agreement.

c) The data gathered regarding this assurance must be included in the RRDS Quarterly Reports for review by DOH WMS. That staff, in consultation with the RRDS will evaluate the need to change and/or improve policies/procedures.

Participants are afforded choice between waiver services and institutional care.
Activities:

a) The RRDC staff is responsible for outreach and community education regarding the TBI Waiver.
b) The RRDS interviews all potential waiver participants and offers them informed choice between community-based services versus institutional care. The RRDS tracks the number of potential waiver participants interviewed and the number of potential waiver participants who chose waiver services instead of institutionalization.
c) The RRDS documents that potential waiver participants are offered choice by having the potential waiver participant sign the Freedom of Choice form during the initial phase of the application process.
d) The DOH WMS conducts an annual random retrospective review of five-percent (5%) of waiver participant records in Year One of the waiver, two-percent (2%) in Year Two, and one-percent (1%) in Year Three to assure that the Freedom of Choice form was completed and included in the Application Packet.
e) DOH WMS conducts annual visits to the RRDC. These visits include review of Freedom of Choice forms.
f) Potential waiver participants may contact the TBI Complaint Line to express concerns about Freedom of Choice. DOH WMS will monitor the TBI Complaint Line and take appropriate action to assure all potential waiver participants are offered the choice between community based services, including waiver services and institutional care.
g) DOH conducts an annual Participant Satisfaction Survey to assure waiver participants continue to be afforded choice between community services and institutional care. DOH WMS monitors these Surveys for trends related to freedom of choice and issues corrective action as necessary for remediation and improvement.
h) The data gathered regarding this assurance must be included in the RRDS Quarterly Reports for review by DOH WMS. That staff, in consultation with the RRDS will evaluate the need to change and/or improve policies/procedures.

Participants are afforded choice between/among waiver services and providers.
Activities:

a) In the intake interview with the potential waiver participant, the RRDS explains the use of waiver services.
b) During the intake interview, the RRDS assures individuals are offered choice in selection of SC by providing a list of available SC agencies. The potential waiver participant is encouraged to interview SCs prior to making a selection. Upon selection of a SC by the waiver participant, the RRDS assures the Service Coordination Selection form is completed and signed by the waiver participant and maintained in his/her record.
c) The waiver participant is informed during the initial interview with the RRDS and again by the SC that at any time he/she may request a change in waiver providers, including SCs and complete a Change of Provider Request form. The SC assures each waiver participant is given a list of available qualified waiver service providers for selection which is attached to the Change of Provider Request form. Upon selection of waiver service provider(s), the SC will assure the agency can accept the waiver participant. The SC maintains the completed and signed Change of Provider Request form in the participant's record.

d) The SC assures the waiver participant signs the SP indicating his/her acceptance of waiver providers and waiver services.
e) On a semi-annual basis, the SC assures the waiver participant reviews and signs a Waiver Participant Rights and Responsibilities form which includes information regarding a waiver participant's right to choose between/among waiver services/providers. A copy is kept in the waiver participant's record and is given to the waiver participant.
f) All waiver providers are responsible for conducting annual Participant Satisfaction Surveys containing questions about "choice". These surveys can be reviewed during DOH surveys and upon request by the RRDS and DOH WMS.
g) DOH WMS will conduct annual random retrospective review of at least five-percent (5%) of waiver participant records in Year One of the waiver, two-percent (2%) in Year Two, and one-percent (1%) in Year Three to assure Provider Selection forms have been appropriately completed and to monitor trends that warrant changes in protocol.
h) During annual Regional Forums DOH WMS collects feedback from waiver participants regarding their choice of waiver services. That staff analyzes the information to determine if agency specific or system-wide improvements are needed.
i) The data gathered regarding this assurance must be included in the RRDS Quarterly Reports for review by DOH WMS. That staff, in consultation with the RRDS will evaluate the need to change and/or improve policies/procedures.

Health and Welfare

There is continuous monitoring of the health and welfare of waiver participant and remediation actions are initiated when appropriate.

Activities:

a) The SC serves as a liaison between waiver providers facilitating communication regarding issues pertinent to the waiver participant's health and welfare.
b) The SC will provide all waiver participants with a Waiver Contact Sheet listing SC, other waiver service providers, RRDS, and complaint line. This information will be updated and provided to the waiver participant if any entity should change. These contacts allow for easier accessibility for waiver participants to communicate concerns regarding health and welfare.
c) At least at the 30 day and mid service review, the SC will facilitate Team Meetings with the waiver participant, anyone he/she chooses to attend, service providers and other key parties to review and revise the SP.
d) Every SP and PPO will be reviewed by the RRDS to assure the waiver participant's health and welfare needs are being met.
e) The SC will conduct face-to-face visits with the waiver participant based on the participant's health and welfare needs.
f) All waiver provider staff will be trained to observe and report changes in the waiver participant's behavioral, physical and cognitive functioning and the process to follow if concerns arise.
g) Waiver providers conduct a random sample of Participant Satisfaction Surveys annually including health and welfare issues.
h) DOH WMS monitors calls received from the TBI Complaint Line for trends.
i) All SRI reports received will be investigated according to policy and procedure.
j) On an ongoing basis, the RRDC reviews the SRIs for trends and, as needed, the DOH WMS may provide technical assistance to waiver providers.
k) Waiver providers submit annual reports to the RRDC who reviews and analyzes the information in their region and sends the report to the DOH WMS.

l) DOH WMS initiates the development of a Quality Advisory Board to review statewide trends with a focus on health and welfare.
m) The data gathered regarding this assurance must be included in the RRDS Quarterly Reports for review by DOH WMS. That staff, in consultation with the RRDC will evaluate the need to change and/or improve policies/procedures.
n) If warranted, DOH WMS initiates additional remediation actions including restriction of a provider's opportunity level (vendor hold) for providing services to participants or termination of a provider agreement.
o) DOH WMS manages system performance ongoing based on the outcome of trend analysis, including SRI, complaints/grievances and Participant Satisfaction Surveys.

The state, on an on-going basis, identifies and addresses and seeks to prevent the occurrence of abuse, neglect and exploitation (SRI policy).

Activities:

a) The Program Manual provides each waiver provider with the policies and procedures for SRI including abuse, neglect and exploitation reporting, investigation and monitoring of outcomes.
b) The Program Manual describes the waiver provider's need to have a SIRC which has the responsibility for investigating reports of SRI and Recordable incidents, assuring appropriate and immediate corrective or disciplinary action has been taken and preventive measures are in place. Waiver providers must submit an annual report for review to the RRDC. The RRDC analyzes the data for trends and makes recommendations for changes/improvements on a provider and regional level. This data is compiled and sent by the RRDC to DOH WMS.
c) The RRDC is the primary party to provide training regarding the SRI policy. The RRDS is available for any assistance that may be needed.
d) During surveys, DOH will review a waiver provider's policies and procedures for managing complaints and grievances. The Provider's complaint/grievance log is reviewed to assure appropriate documentation, investigation and resolution has occurred within timeframes specified in the TBI Program Manual. Results of these provider surveys are forwarded to DOH WMS and RRDS for review, discussion and development/implementation of Remediation and/or Improvement initiatives. DOH WMS maintain survey results in a database for regional and statewide trend analysis.
e) The RRDC is the entity responsible for the management of the TBI SRIs Policy and is responsible for alerting the DOH WMS of the most serious reports of allegations.
f) To measure system performance and to identify active or potential instances of abuse, neglect and/or exploitation, DOH annually conducts a random sample of face-to-face Participant Satisfaction Surveys.
g) DOH WMS reviews Participant Satisfaction Surveys conducted , analyzes these for trends and identifies any warranted programmatic changes.
h) To meet this assurance, the DOH Waiver Management unit serves as a centralized collection site to receive data compiled from TBI Complaint Line calls, SRI, Provider survey outcomes as well as quarterly and annual reports. Data is analyzed by staff for regional and statewide trends. Outcomes are reviewed with the RRDC for needed interventions which may include additional training programs, changes and/or improvements in policy/procedure, restriction of provider opportunity level (Vendor Hold) and/or termination of provider agreement.

Service Coordination

Safety and Medical Emergencies After Hours

Policy:
All individuals receiving services with Catholic Charities Disabilities Services will be provided necessary supports and assistance when faced with a safety or medical emergency.

Procedure:

1. In the event of a safety or medical emergency in which the individual is in imminent danger, 911 will be called for immediate assistance.
2. In the event of a safety or medical emergency that does not require immediate intervention, the individual will contact their Service Coordinator or the emergency cell phone (518-369-2234) for assistance. Each individual will be provided with these phone numbers at the time of intake and assist as necessary to post this information near their phone.
3. All individuals will receive a copy of their Plans of Protective Oversight TBI that indicates emergency numbers for that specific individual. The Plan of Protective Oversight is reviewed with the individual and their family/advocate at minimum annually, more frequently if needed.
4. 911 will be called for all medical emergencies.

Required Training for providers through CCDS
Waiver service providers (Service Coordination, Community Integration Counseling, and Positive Behavioral Interventions and Supports Services) are responsible for:
Developing a written training curriculum if one has not been developed by DOH to meet the requirements identified in this section;
Ensuring individuals providing the training meet the qualifications specified in the manual; and
Documenting all training in staff's files, including all related TBI training, seminars and conferences attended, by the provider or other entities.

Basic Orientation Training

Definition
Qualified waiver service provider staff for this group must complete Basic Orientation training within thirty (30) days of beginning service provision to a TBI participant.

The training consists of one-on-one and/or group training to instruct new employees of waiver service providers about general needs of individuals with TBI, the philosophy and policies of the TBI waiver, waiver services and waiver participant's rights and responsibilities.

The requirement for Basic Orientation training will be met by utilizing the approved DOH curriculum entitled "Overview of TBI Waiver Programs".

The Regional Resource Development Specialist (RRDS) will provide Training-Of-Trainer (TOT) programs to the trainers of the waiver service provider agencies so they, in turn can conduct the overview training to their agency staff. The individuals that have attended the TOT program will then be able to train agency staff in this curriculum. Upon completion of the TOT program, the RRDS will give the employee a Certificate of Attendance which will be kept in his/her employee file verifying that he/she has attended the training. This curriculum can be obtained by contacting the Regional Resource Development Center (RRDC) following the successful completion of the training.

Service Specific Training

Definition

Service specific training prepares the waiver service provider staff for the roles and responsibilities specific to the waiver service he/she is qualified to provide. This training must be completed within thirty (30) days of initial employment.

Service specific training consists of one-on-one and/or group training to instruct individual staff of their roles as providers of a specific service. All staff must understand the description of each waiver service written in the Program Manual.

All waiver service providers for this group must include the following information in the curriculum for Service Specific Training:

1. Definition and goals of the service and a detailed job description;
2. Roles and responsibilities of the provider of the specific service;
3. Procedures for completing service-specific assessments;
4. Procedures for effective communication and coordination between staff and Service Coordinator and all waiver and non-waiver service providers;
5. Basic understanding of TBI waiver services and other available community services and funding sources;
6. The prior approval process;
7. Record keeping responsibilities of the specific waiver service providers including Service Plans, Detailed Plans, documentation of encounters, and Individual Service Reports;
8. Team Meeting requirements;
9. Waiver Participant Rights and Responsibilities;
10. Effective interventions during crisis, including behavioral and medical, natural disasters, severe weather, and lack of replacement staff;
11. Basic safety and emergency procedures (e.g. choking, loss of consciousness, breathing difficulties); and
12. Identifying and reporting any changes in the participant's routine use of medication, usual behaviors, mood, personality, sleep patterns, functional and cognitive abilities, appearance and/or lifestyle.

Positive Behavioral Interventions and Supports Services have more clearly defined training requirements which must be adhered to.

Annual Training

Definition

Annual Training is provided to keep waiver service provider staff up to date regarding their roles and responsibilities specific to the waiver service he/she is qualified to provide. Waiver service provider staff must complete an Annual Training program. Annual Training consists of one-on-one and/or group training.

Annual Training requirements for this group include at a minimum:

- A review of TBI Participant Rights and Responsibilities;
- A review of the TBI Incident Reporting Policy and Complaint Procedure;
- A review of all new policies and/or procedures required by the TBI Waiver which impact the services provided.
- Additional topics relating to findings of satisfaction surveys, incident reports and trend analyses.

- Staff will rotate attendance at the RRDC TBI monthly meetings. Minutes are taken and staff are required to review the minutes which are emailed to the department each month. Minutes are also placed on a shared drive.

Training Employees concerning TBI Waiver and Participant Rights
Policy:
All providers of TBI Services within Catholic Charities Disabilities Services Service Coordination will be trained in TBI Waiver and participant rights.

1. The Director/Associate Directors will assure the training of all Service Coordination staff according to TBI regulations and the training manual of Catholic Charities Disabilities Services.
2. There will be a list of all trainings provided which includes: who provided the training, who attended the training, when and where the training occurred, the goals of the training, the tools used to evaluate whether the training accomplished its goals, and the next steps in the training process.
3. There will be a formal list of all TBI related training, seminars or workshops attended by the Service Coordinator. The Service Coordinator and the Human Resources (HR) Department will maintain this formal list utilizing the appropriate Service Coordination Training Record Form. Each Service Coordinator will retain a copy of the SC training record form for him or herself and HR will retain copies of all training records in the Training folders/personnel files.
4. All Service Coordinators shall be cross trained for NYS DOH TBI Waiver and NYS OPWDD in order to provide quality services to individuals with disabilities.
5. All Service Coordinators will take the CORE training for Service Coordinators (NYS OWPDD) within the first 6 months of hire as well as 15 hours per year of approved training, with 4 of the 6 mandatory trainings (OPWDD) within the first 2 years of employment. Annually, all staff will be trained and updated in Participant Rights, Incident Reporting, Corporate Compliance, Quality Assurance and HIPAA; and other trainings offered through HR, QA, and Catholic Charities of the Diocese of Albany.

Community Transition Services

Scope of Services
Community Transitional Services (CTS) are defined as individually designed services and project management intended to assist a waiver participant in transitioning from a nursing home to living in the community. CTS is a one-time service per waiver enrollment. If the waiver participant is discontinued from the program and re-enters a nursing home, they can access this service again upon discharge. This service is only provided when transitioning from a nursing home or long term care facility. These funds are not available for moves from the participant's home in the community to another location in the community. The service will not be used to purchase recreational items, such as televisions, DVD players or music systems. Approved costs are covered by CTS up to thirty (30) days prior to the individual's discharge from the nursing home/long term care facility into the community.

Community Transition Services for Individuals enrolled in the TBI Waiver
Policy:
Applicants for the TBI Waiver who have selected Catholic Charities Disabilities Services for Community Transitional Services (CTS) will be provided assistance in transitioning from a nursing home to living in the community upon RRDC approval.

Procedure:

1. Upon the Applicant's selection for CCDS as the CTS waiver service provider, The Service Coordinator will complete the Provider Selection Request form with the participant and send the completed and signed form to the RRDC;
2. The SC will ensure the applicant's ISP indicates the need for Community Transitional Services, the Service Coordinator must obtain, complete, and attach all applicable supporting documentation (e.g. Waiver Service Provider Selection form and CTS Costs Description and Projection form)
3. All CTS expenses must be included in the approved Initial Service Plan and provided by agencies approved by the RRDC. Reimbursement is not provided for items purchased prior to RRDS approval.
4. This service is only provided when transitioning from a nursing home or long term care facility.
5. Any not for profit health and human service agency that has both the personnel and expertise to provide the Community Transitional Services and is an approved Medicaid provider may provide Community Transitional Services or may subcontract with a qualified person or entity to provide Community Transitional Services. There are no minimum staff qualifications to provide Community Transitional Services. The qualifications are specific to the licensure and registration of the provider agency as a whole.

Contacting the CCDS Service Coordination Department, outside of normal working hours
Policy:
Individuals receiving Community Transition Services through Catholic Charities Disabilities Services will be provided funding for the reasonable costs of onetime set-up expenses for individuals transitioning from a nursing home to their own home or apartment in the community.

Procedure:
1. Individuals will sign a Provider Selection.
2. The Service Coordination Department Staff and Administrative Staff from Catholic Charities Disabilities Services will carry emergency cell phones, sharing the on-call responsibility on a rotating schedule.
3. In the event that an individual has an emergency for which they need a Service Coordinator, they should call this phone and they will be assisted. If need be, the assigned Service Coordinator will be contacted to assist the individual.

Billing
1. To ensure providers of Community Transitional Services (CTS) are billing properly, providers are required to submit projected cost estimates and final cost reports to the Service Coordinator. Each specific payment is made based on the tasks performed or the equipment or parts purchased on behalf of the participant. These reports are provided to the RRDC for approval. Payment reports for these services are reviewed by NYSDOH and the RRDC annually to ensure the billed amount is the same as the amount approved. If there is a difference between the projected and actual costs, the RRDC requires an Addendum to the Service Plan to justify the increase.

2. This service includes: the cost of moving furniture and other belongings; security deposits; broker's fees required to obtain a lease on an apartment or home; purchasing essential home furnishings; set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); and health and safety assurances such as pest removal, allergen control, or one time cleaning prior to occupancy, costs and/or fees associated with securing the service.

3. Maximum up to $8000 per waiver enrollment. Due to the needs of the target population, provisions contained within this service allow for costs that may exceed CFCO state plan service
4. Security deposits funded through this service and returned upon vacating the residence or dwelling must be returned to the CTS provider. Upon return of the funds, the CTS provider must submit a paid claim void to eMedNY.
5. Reimbursement is one hundred percent (100%) of the approved cost.